Funding Mechanics Protocol,
Performance Measurement Specifications, and
Data Submission Guidelines for
Quality Improvement Program - New Jersey (QIP-NJ)

v 5.1 (updated: July 2026)

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I. General Overview

A. Background

The Quality Improvement Program – New Jersey (QIP-NJ) is a multi-year successor program to the Delivery System Reform Incentive Payment (DSRIP) program. Subject to federal Centers for Medicare and Medicaid Services (CMS) approval, QIP-NJ will be administered by New Jersey Department of Health (DOH, herein referred to as the State), in conjunction with the Department of Human Services (DHS), as a Medicaid pay-for-performance initiative, open to all acute care hospitals (ACHs) statewide. The primary purpose of QIP-NJ is to advance quality improvements in behavioral and maternal health services statewide.

Participating hospitals will earn QIP-NJ incentive payments by satisfying performance targets on State-selected quality measures that demonstrate:

- Improvements in connections to behavioral health services;
- Reductions in potentially preventable utilization for the behavioral health population;
- Improvements in maternal care processes; and
- Reductions in maternal morbidity.

The State convened a Quality Measures Committee (QMC), comprised of experts in the fields of mental health, substance use disorder (SUD), maternal health, and quality measurement, to provide on-going critical input for QIP-NJ. The performance measures proposed by the State and further recommended by the QMC for inclusion in the QIP-NJ are detailed within this "Funding Mechanics Protocol, Performance Measurement Specifications, and Data Submission Guidelines" (Databook) document.

This Databook provides submission guidelines and technical specifications for the twenty-two selected quality measures (twelve of which relate to behavioral health populations and ten to maternal health populations, two measures are included across both populations). This Databook also includes program measurement methods for calculation, standardized diagnostic coding, measure reporting requirements, and incentive payment impact weights, among other elements.

Additional documents supporting the Databook, include:

- Addendum A: Value Code Sets by Measure (Value Set Compendium available in Excel)
- Addendum B: Standard Reporting Template
- Addendum C: Standard Reporting Template Guidance
- Addendum D: Databook Change Log

The first three addenda may be found on the QIP-NJ Resources page.

B. Medicaid Management Information System (MMIS) Measures – Administrative claims data

The primary method to compute measure performance is through administrative claims data submitted for payment to the New Jersey Department of Medical Assistance and Human Services (DMAHS). To

measure clinical performance across settings of care for the relevant population, the State, subject to CMS approval, will calculate claims-based measures on behalf of program participating hospitals.

Primarily, administrative claims data are generated from a wide array of services rendered in professional and institutional settings from various provider types. Subsequently, claims data are submitted and adjudicated within the MMIS. This information is then provided to CMS and retained in the federal Medicaid Statistical Information System (MSIS) data warehouse. Further, the data are copied and transferred for storage to another dedicated repository where it is maintained by a DMAHS vendor.

Individual utilization that may be used to measure quality performance are contained within administrative claims data. Primarily, this data captures the occurrence of a behavioral or maternal health service (or lack thereof). Retrospective claims analysis includes claims from relevant providers seen by the individual, not merely the hospital to whom the individual is attributed (section "Attribution Methodology Overview").

C. Non-claims-based measures: Chart / Electronic Health Records (EHR) measures

Although historically, medical records have been in the form of paper records, through Meaningful Use and other endeavors, many hospitals have shifted towards widespread adoption of EHR systems. The evolution of digital quality measurement has afforded more seamless transfer of patient data with added benefits including increased harmonization with industry standards, less subjective interpretation, and minimized human error through automation. Irrespective of the medium and tools used, medical record review and abstraction requires the retrospective collection of information from patient charts.

Hospitals may find that performing queries of their EHR system more efficiently and robustly identifies individuals that meet, or do not meet, measure criteria. Depending upon how the given EHR system is setup and governed, however, data elements may not be required for certain fields or modules. Moreover, valuable data may be within an unstructured format (e.g., contained within medical notes). Understandably, this may be challenging to abstract without using advanced programming techniques, such as natural language processing.

In calculating required non-claims-based measures, hospitals may rely on multiple sources for searching and obtaining necessary data aligned with the measure's specifications and calculation methods. This could include both data abstracted from EHR systems as well as paper chart sources.

The State reserves the right to audit individual claims, charts, and EHR data to perform primary source validation to ensure that sampled data have been collected, interpreted, and transmitted correctly.

i. Special Considerations for Measures Requiring an Approved Tool

Three measures require validated screening tools. Approved tools are listed in the latest version of the Databook.

While the NJ Department of Health (DOH) takes the QMC's feedback under advisement, DOH reserves the right to make the final decision on whether to approve, defer, or deny all screening tools.

Once a tool has been approved, it can be used for all subsequent measurement years of QIP-NJ. Pre-approved tools listed in the QIP-NJ Databook are approved for all years of the program, regardless of when a hospital submitted.

Hospitals without approved screening tools for the MY will not be able to submit tools at the time of non-claims-based measure submissions. If a hospital is not using a pre-approved tool and failed to submit a hospital-specific tool by the deadline in the corresponding submission period, it will not be able to perform on the measure.

D. Non-claims-based measures: Instrument-based measures

Six instrument-based measures are included. Each will be used to collect data specific to the behavioral and maternal health populations attributed to a participating hospital. Instrument-based measures are **reporting only.** Detail on the mechanics surrounding payment is detailed under section "Payment Arrangement". These measures and their applicability to the two program populations are as follows:

Measure #	Measure Name and National Quality Forum (NQF) #	Measure Steward	Impact on Payment
BH10	3-Item Care Transitions Measure (CTM-3) - NQF #0228	University of Colorado Denver Anschutz Medical Campus	Reporting only
M008	3-Item Care Transitions Measure (CTM-3) – NQF #0228	University of Colorado Denver Anschutz Medical Campus	Reporting only
BH11	Use of a Standardized Screening Tool for Social Determinants of Health (4 Domains)	NJ DOH	Reporting only
M009	Use of a Standardized Screening Tool for Social Determinants of Health (5 Domains)	NJ DOH	Reporting only
BH12	Reducing Disparities and Improving Patient Experience Through Targeted Training	NJ DOH	Reporting only
M010	Reducing Disparities and Improving Patient Experience Through Targeted Training	NJ DOH	Reporting only

Figure 1. Non-claims-based measures: Instrument-based measures

E. Data submission procedures of non-claims-based measures

The provided data file format, known as the Standard Reporting Template, and submission instructions for chart / EHR and instrument-based measures are to be used as a guideline for creating standardized "flat file" submissions based on data abstracted from a participating hospital's EHR using the patient attribution rosters. These files must be pipe-delimited ("|") to enable additional delimiter values required

in collected data (such as commas and dashes). If a hospital wishes to submit a flat file with alternative delimiters, they should contact the QIP-NJ team to discuss feasibility.

Should a participating hospital be unable to develop required flat files, data must be entered either manually or via export into the Microsoft Excel template provided.

All collected data are eligible to receive a preliminary validation review prior to importation into a repository where programming scripts will perform further verification processes. A summary report will be generated for each file identifying any errors or incompleteness requiring additional action. Incentive payments will be contingent upon fully executing all program submission guidelines.

F. Reporting schedule for submission of non-claims-based measures

MY	Measurement Period	Submission Deadline[1]
Baseline (Y0)	7/1/2020 – 12/31/2020	09/30/2021
MY1	7/1/2021 – 12/31/2021	07/22/2022
MY2	1/1/2022 – 12/31/2022	07/24/2023
MY3	1/1/2023 – 12/31/2023	08/07/2024
MY4	1/1/2024 – 12/31/2024	08/01/2025
MY5	1/1/2025 – 12/31/2025	08/11/2026

Figure 1. Reporting schedule for submission of non-claims-based measures

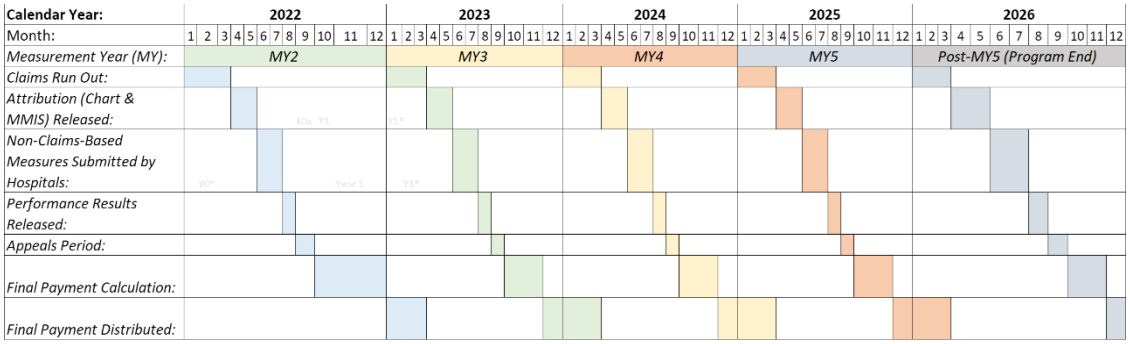

Figure 2. QIP-NJ MY0-MY5 Timeline

Measurement Year (MY)	Dates
MY0 (Baseline)	July 1, 2020 – December 31, 2020
MY1	July 1, 2021 – December 31, 2021
MY2	January 1, 2022 – December 31, 2022
MY3	January 1, 2023 – December 31, 2023
MY4	January 1, 2024 – December 31, 2024
MY5	January 1, 2025 – December 31, 2025

Figure 3. QIP-NJ MYs

[1] Dates are subject to change

G. Small Denominators

Where a hospital does not meet the minimum denominator requirement for a measure, the measure must still be reported (for non-claims-based measures) but will be removed from performance payment consideration for the MY and the subsequent MY. Incentive payments attached to measures that have been removed will be reallocated across remaining measures for that population.

Hospitals must be able to satisfy the denominator reporting requirements of at least one measure per participating population (Behavioral Health or Maternal Health populations) to remain eligible for payments associated with that population. Minimum denominator requirements will vary by measure:

- MMIS - Denominator with fewer than 30 will not be included in payment calculations;
- Chart / EHR - Denominators with fewer than that which is identified by the applicable sampling table (30) will not be included in payment calculations.

H. Payment Arrangement

i. Gap-to-Goal Methodology

Participating hospitals are expected to achieve statewide performance benchmarks for each measure by the end of this multi-year program. Individual participating hospital targets, based on the hospital's baseline performance for each measure, will be assigned to hospitals annually using a gap-to-goal methodology. The State will first identify a uniform annual percentage of the gap between the statewide goal and baseline performance that each hospital must achieve on each measure. Full readjustment of annual percentages will occur for hospitals meeting performance targets, while partial readjustment will occur for hospitals failing to meet performance targets.

Payment amounts are based on two factors:

Behavioral health:

1) The number of Medicaid Managed Care (MMC)-enrolled individuals with a principal diagnosis[2] of behavioral health who are attributed to the participating hospital for the measurement period, and;
2) Whether performance targets have been met.

Maternal health:

1) The number of MMC-enrolled individuals who delivered in the participating hospital during the measurement period, and;
2) Whether performance targets have been met.

To determine each hospital's payment, the State will annually generate a list of MMC-enrolled individuals attributed to each hospital during the measurement period. The State will then calculate for each hospital,

[2] The principal diagnosis, as defined in the National Uniform Claim Committee (NUCC) Official UB-04 Data Specifications Manual, is "the condition established after study to be chiefly responsible for occasioning the admission of the patient for care" and is reported as the principal diagnosis on the claim.

their proportion of attributed patients in comparison to the entire program's eligible patient population. This proportion will determine the eligible share of total program incentive payments for each hospital.

The State shall then review the hospital performance on State-selected metrics across attributed population. For each metric there shall be a hospital-specific target set using the "gap-to-goal" methodology compared to a statewide goal.

All pay-for-performance measures within both the behavioral health and maternal health populations are weighted equally. When a hospital meets or exceeds a measure's performance target or the statewide goal, the hospital will earn a portion of their total possible funding, as determined by attribution. Funding shall not be awarded when the hospital fails to meet a measure's performance target (inclusive of partial achievement) for that measurement year. In addition, should a hospital fail to submit the necessary data to calculate performance on non-claims-based measures, the hospital will forfeit funding across all measures for that population (maternal or behavioral health).

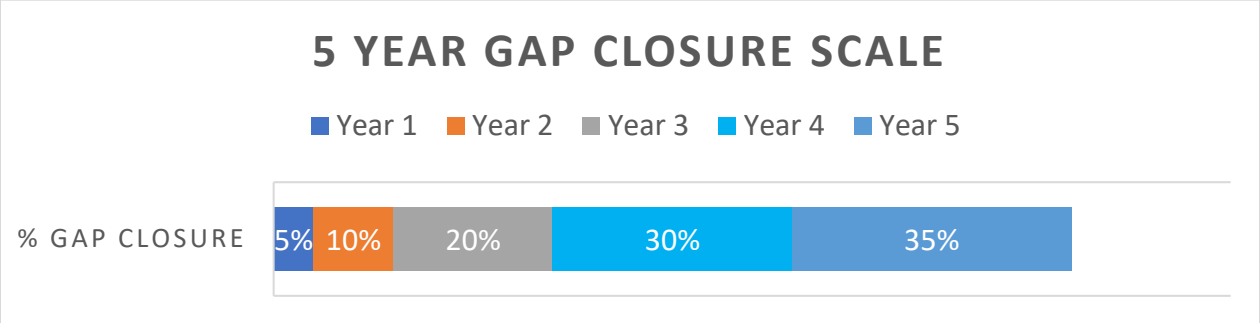

Figure 4. QIP-NJ Five Year Gap Closure Scale

In the event a hospital has a denominator too small to be significant on a given measure, the measure shall not be considered towards the overall performance of the hospital, and the Target Funding shall be spread across the remaining measures. Where the measure requires hospital submission of data, submission shall still be required, but with no impact on the performance calculation for incentive funds.

Any hospital failing to meet a performance target will forfeit the measure's associated funding amount. Hospitals meeting or exceeding performance targets may be eligible to collect some proportion of these undistributed funds. The State shall assign the portion of undistributed funds to be redistributed through each measure. Hospitals meeting or exceeding their individual target on that measure shall receive a share of the unearned funds allocated to that measure, based on their share of attribution for the behavioral health or maternal health population. Should more than 85% of hospitals fail to meet performance targets on any given measure, all unearned funds associated with that measure will not be forfeited but will instead be redistributed across each hospital's remaining measures, within that measure set (maternal or behavioral health).

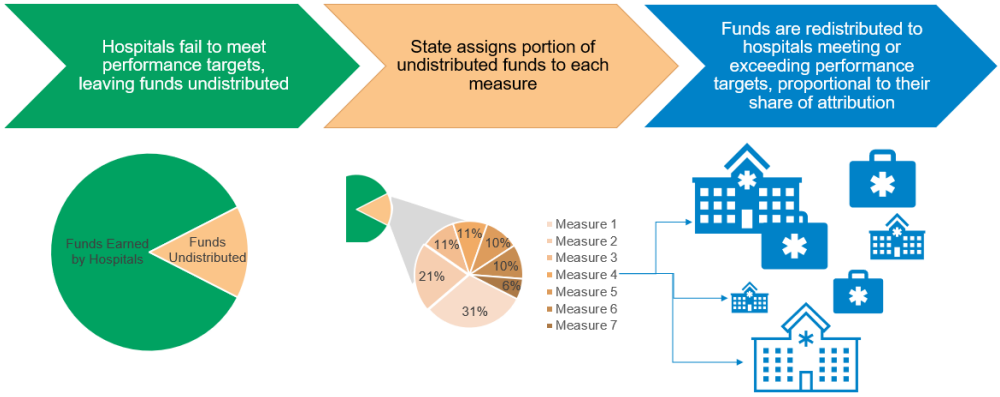

Figure 5. QIP-NJ Redistribution Methodology

ii. Funds Flow

The State will use MMIS data to determine amounts to be paid to individual hospitals after the close of the rating period based on the volume of MMC-enrolled individuals in the focus populations attributed to the hospital, and the hospital's performance on program measures and any related redistribution earnings.

The State will use the same MMIS data to allocate hospital specific payment amounts into rate cells and federal funding groups under the following categories: Expansion, Title XXI and non-Expansion Title XIX.

The State will provide the full funding for QIP-NJ through financial transactions to the Managed Care Organizations (MCOs) after the close of the rating period. The Funding will be provided to each MCO based on the allocation of total incentives earned by each hospital across each MCO with which that hospital has a contract. Such allocation will be proportionate to the volume of total payments by each MCO to the hospital during the rating period. The MCOs will be required to disburse single annual payments to hospitals in accordance with Managed Care contract conditions.

The State will provide a directed payment schedule to each MCO showing payments due to each hospital based on the hospital's performance. In following the proportional algorithm mentioned above, there may be occasions in which a hospital will receive the total sum of their earned incentive payment from more than one MCO.

I. Sampling Methodology

Sampling is permitted when calculating the following measures:

Measure #	Measure Name and NQF #	Measure Steward	Data Source
BH07	Preventative Care and Screening: Screening for Depression and Follow-Up – NQF #0418	CMS	Chart/EHR
BH08	Substance Use Screening and Intervention Composite – NQF #2597	ASAM	Chart/EHR
BH09	Timely Transmission of the Transition Record- NQF #0648	AMA-PCPI	Chart/EHR

BH10	3-Item Care Transitions Measure (CTM-3) - NQF #0228	University of Colorado Denver Anschutz Medical Campus	Instrument-Based
BH11	Use of a Standardized Screening Tool for Social Determinants of Health (4 Domains)	NJ DOH	Instrument-Based
M002	PC-02 Cesarean Birth - NQF #0471	Joint Commission	Chart/EHR
M003	Measure M003: Postpartum Depression Screening – NQF #1401	NCQA	Chart/EHR
M006	Timely Transmission of the Transition Record- NQF #0648	AMA-PCPI	Chart/EHR
M007	Treatment of Severe Hypertension	Alliance for Innovation on Maternal Health (AIM)	Chart/EHR
M008	3-Item Care Transitions Measure (CTM-3) – NQF #0228	University of Colorado Denver Anschutz Medical Campus	Instrument-Based
M009	Use of a Standardized Screening Tool for Social Determinants of Health (5 Domains)	NJ DOH	Instrument-Based

Figure 6. Chart/EHR Measures Eligible for Sampling

Sampling may be permitted based upon the volume of attributed individuals. For behavioral health measurement, this is determined by the total number of individuals in the attributed population with an encounter in an appropriate setting during the MY. For maternal health measurement, sampling is determined by the total number of attributed individuals admitted to the hospital for labor and delivery during the MY.

The sampling methodology used for QIP-NJ should follow:

Administrative pull → initial patient population (IPP) → # of resultant individuals in IPP used to determine sample size → randomize order of individuals on IPP list & pull sample → complete chart abstraction for selected sample → finalize metrics numerator and denominator.

If a hospital cannot remove exclusions and denominator non-compliant individuals prior to abstraction, they may use the initial patient population; however, they will need to backfill after abstraction to ensure there is a minimum denominator of 30.

Attributed Individuals Population Size (Denominator)	**Calculated Minimum Random Sample Size**
>= 501	101
150 – 500	20% of the population
30 – 149	30
< 30	No sampling permitted. 100% of the attributed individuals meeting the measure criteria must be reported.

Figure 7. Sample Size Calculation

Sample Size Calculation Examples:

- A hospital has 700 behavioral health attributed individuals eligible for depression screening in MY1. Using the above table, 101 attributed individuals may be sampled.
- A hospital's maternal health total attributed individuals is 400. Using the above table, 400 * (0.20) = 80 attributed individuals may be sampled.
- A hospital has 43 behavioral health attributed individuals eligible for depression screening during the MY. Using the above table, 30 attributed individuals may be sampled.
- A hospital has 20 maternal health attributed individuals eligible for survey during the MY Using the above table, 100% of the attributed individuals must be reported; therefore, no sampling is permitted.

Hospitals choosing to report the results of the above measures based on a sampling methodology as opposed to reporting on all patients must ensure that all sampling conditions associated with that measure have been met. Each measure reported through a sample must include a description of steps taken to validate that sampling requirement have been met.

When a sample is taken for a measure and exclusions force that population below the 30-patient denominator requirement, the process for backfilling patients is as follows:
• Step 1: Identify the eligible population from the attribution roster and remove all required exclusions based upon the respective measure specifications. All required exclusions must be removed from the final eligible population.
• Step 2: Search chart/EHR systems to identify numerator events for all members in the eligible population.
• Step 3: If applicable, for members for whom non-claims-based data do not show a positive numerator event (numerator compliance), search non-claims-based data for an exclusion to the service/procedure being measured.
• Step 4: Exclude from the eligible population, members from step 3 for whom system data identified an exclusion to the service or procedure being measured.

J. Measure Stewards and Citations

QIP-NJ performance measures were selected based, in part, upon their endorsement by industry leading standards organizations. Each entity that develops a given measure is referred to as that measure's steward and, as such, is responsible for updating the measures' specifications. Measure specifications that are made available to the public typically include descriptions of inclusionary and exclusionary conditions related to measure numerators and denominators. Prevailing debate related to the applicability of a particular measure or its limitations or advantages when compared to other similar measures are also frequently included in measure specifications. The measure steward is identified for each state-selected quality measure along with respective hyperlinks under each measure to review detail and change history. Wherever possible, the value sets are noted and are contained in Appendix A.

Measure stewards that are represented within the first year of QIP-NJ and their respective citations include:

1. Alliance for Innovation on Maternal Health (AIM)

- Measure content sources include the AIM SMM Codes List and literature pertaining to severe hypertension (SHTN) during pregnancy and the postpartum period. AIM has neither reviewed nor approved the modified measure.

2. American Medical Association – Physician Consortium for Performance Improvement (AMA-PCPI)
    - Measure content has been sourced from AMA-PCPI®; PCPI® has neither reviewed nor approved the modified measure. Although AMA-PCPI® has ceased operations as of July 2020, measurement resources will be housed at the American College of Physicians beginning in November 2020.
3. American Society of Addiction Medicine (ASAM)
    - Measure content has been sourced from ASAM. ASAM has neither reviewed nor approved the modified measure.
4. CMS
    - Measure content has been sourced from CMS. CMS has neither reviewed nor approved the modified measure.
5. The Joint Commission
    - The Specifications Manual for National Inpatient Quality Measures is the collaborative work of the CMS and The Joint Commission. The Specifications Manual is periodically updated by CMS and The Joint Commission. Users of the Specifications Manual for National Hospital Inpatient Quality Measures must update their software and associated documentation based on the published manual production timelines.
6. National Committee for Quality Assurance (NCQA)
    - Measure content has been sourced from the Healthcare Effectiveness Data and Information Set (HEDIS), Volume 2, Technical Specifications for Health Plans by NCQA and modified by QIP-NJ. HEDIS® is a registered trademark of the NCQA. NCQA has neither reviewed nor approved these modified measures.
7. NJ DOH
    - NJ DOH has compiled a list of appropriate screening tools for Social Determinants of Health (SDOH). If a tool is not listed in the measure specification for BH11 / M009, hospitals must submit their tool to QIP-NJ@pcgus.com for approval and to map the domains for data collection.
8. University of Colorado Denver Anschutz Medical Campus
    - Measure content has been sourced from University of Colorado Denver Anschutz Medical Campus; the University has neither reviewed nor approved this modified measure.

i. Measure Steward Specification Version Control

Generally, measure specifications as maintained by stewards have been adhered to within the Databook. In some instances, however, it is necessary to adjust measure specifications to better align with the goals, and populations (e.g., measurement periods, age requirements, state billing guidelines) of QIP-NJ.

Where applicable, material deviations from measure steward specifications have been indicated along with the reason underlying the change. Measure specifications and referenced code sets have been updated to reflect current recommendations though these may be further updated prior to the start each program year.

As each measure steward is responsible for the maintenance of the measure(s) they develop, each steward may follow different maintenance schedules. To ensure consistent usage by QIP-NJ providers, the State will evaluate the most recent finalized version made publicly available prior to the end of each calendar year. As necessary, the Databook will be updated in a way which indicates whether a newer or older version is to be followed and what additional changes may be relevant to the QIP-NJ program. The State reserves the right to adjust elements of the measurement specifications and the statewide benchmark based on performance.

Continual assessment of hospital data collected and frequent touchpoints and collaboration with stakeholders will help inform decision-making regarding the measures' status. This process may include, but not be limited to: determining whether the current measures' specifications, benchmarks, and payment structure require modifications and, whether measures will be added into (and/or subtracted from) the two domains.

K. Attribution Methodology Overview

At the close of each measurement period and its necessary claims runout period, the State will extract claims data related to the attributed populations. Attribution rosters will then be developed using the following process:

Maternal Health: Attribution for the maternal health population will be determined by the following criteria:

- The hospital at which a birth occurs,
- The admission date for that birth, and
- MMC[3] enrollment as of December 31st of the applicable measurement year.

This allows for an individual giving birth prior to enrollment in MMC to be attributed so long as they are enrolled by the close of the MY and the birth is documented on a Medicaid paid claim. Birthing individuals who deliver twice within one MY, will be attributed to each of the hospitals at which they delivered.

Behavioral Health:

The following steps apply to the BH attribution process:

Step 1 - an individual must meet the diagnosis and utilization-based eligibility criteria to be deemed attributable. The primary diagnosis[4] may be from any provider, at any point in the measurement period, not just the provider visit(s) that lead(s) to their attribution at a specific hospital.

[3] The five health plans that currently participate in NJ FamilyCare program: Aetna, Wellpoint fka AMERIGROUP NJ, Horizon NJ Health, UnitedHealthcare NJ, and Fidelis fka WellCare. If an individual is enrolled in either the HMO or D-SNP of any of these five health plans, they are considered eligible. These plans may be the primary or secondary payers for the enrolled beneficiary. Individuals enrolled in PACE, Medicare Advantage, and other commercial insurance plans are not eligible for QIP-NJ (refer to 2021 NJMMIS Quick Guide, section "21. HMO/D-SNP/PACE Plan Names" (031099).

[4] The BH primary diagnoses are catalogued in the Value Set Compendium (VSC), tab "BH09_00"; the M primary diagnoses are catalogued in tab "M06_00". The UB revenue codes are catalogued in tab "App_Revenue" starting in v1.2 of the VSC.

Step 2 – using the BH attribution hierarchy, the individual is assigned to the hospital most likely to impact their quality of BH care, regardless of the diagnoses on the claims at that facility.

To this end, an outpatient Obstetrical claim could attribute an individual under the "outpatient physical health" level of the hierarchy, even if the primary diagnosis on the claim is pregnancy-related, so long as the individual was not already attributed at the level above it on the hierarchy.

The hierarchy for BH is as follows:

- For individuals who have three or more outpatient behavioral health claims during the MY, AND two or more outpatient behavioral health claims with a single hospital, the individual will be attributed to the hospital at which the plurality of the individual's outpatient behavioral health claims have been submitted.
- For individuals not attributed through the above step, who have three or more outpatient physical health claims during the MY, AND two or more outpatient physical health claims with a single hospital, the individual will be attributed to the hospital at which the plurality of the individual's outpatient physical health claims have been submitted.
- For individuals not attributed through any of the aforementioned steps, who have three or more emergency department claims during the MY, AND two or more emergency department claims with a single hospital, the individual will be attributed to the hospital at which the plurality of the individual's emergency claims have been submitted.
- For individuals not attributed through any prior step, if the individual has any inpatient claims (Maternity, Psych or Med/Surg), the individual will be attributed to the hospital at which the plurality of the individual's inpatient claims has been submitted.
- If none of the above criteria are met, the individual will not be attributed to any participating hospital.

Where two hospitals have the same volume of claims in any category above, the most recent visit of that type will be used as a tiebreaker.

As part of the Program Evaluation design for QIP-NJ, attribution results will be reviewed annually for:

- Aggregate attributable population over projections/baseline; and
- Growth or loss in volume over baseline for each hospital, where changes over 10% will trigger a data integrity review.

i. MMIS Measures

The steps that follow describe the process that the State will take on behalf of hospitals to calculate MMIS administrative data measures.

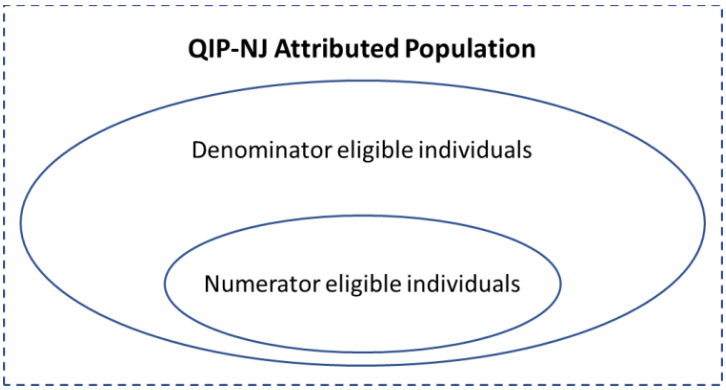

Figure 8. QIP-NJ Attributed Population for MMIS measures

Step 1: The State identifies the hospital-specific attributed population for each MMIS-calculated measure.

Step 2: Of those attributed individuals, the State identifies individuals satisfying denominator (D) inclusion criteria.

Step 3: Of denominator eligible individuals, the State identifies individuals that meet numerator (N) inclusion criteria.

Step 4: The State computes the result.

$$\text{Result} = \frac{\text{Numerator}}{\text{Denominator}}$$

Performance measures from a variety of care settings are represented within the QIP-NJ measure set. The setting of care for each measure is indicated in the Measure Specification Description and Definitions.

a. Inpatient or ED Setting – refers to any MMIS measure that only considers care provided within inpatient or ED settings. This could be monitoring a single episode of care or comparing care across inpatient or ED events[5].
b. Outpatient Setting – refers to any MMIS measure that only considers care that was provided in an outpatient setting (e.g., hospital-based clinic, primary care office, Federally Qualified Health Center (FQHC), behavioral health clinic, etc.). This could be monitoring care for a single date of service or comparing care across multiple outpatient visits.
c. Multi-Setting – refers to any MMIS measure that considers care received in multiple settings of care. This may compare care across multiple service events (such as follow-up after inpatient hospitalization with an outpatient service), or to capture diagnosis and/or procedure codes to reflect an individual's treatment history in multiple eligible settings (screening events taking place in both outpatient and ED setting).

[5] For further insight into place of service definitions, refer to the value code set associated with each specific measure.

ii. Chart / EHR Measures

The steps that follow describe the process that participating hospitals will take to abstract and calculate measures that require chart or EHR-collected data. In addition to the steps highlighted below, hospitals will need to complete the Standard Reporting Template containing individual level information including, but not limited to, Medicaid ID, patient name, date of birth, and inclusion in the numerator and/or denominator of each measure. Hospitals must retain copies of any reports that pertain to steps taken to calculate chart/EHR measures in case of audit.

The following graphic represents data that is limited to the hospital's data only.

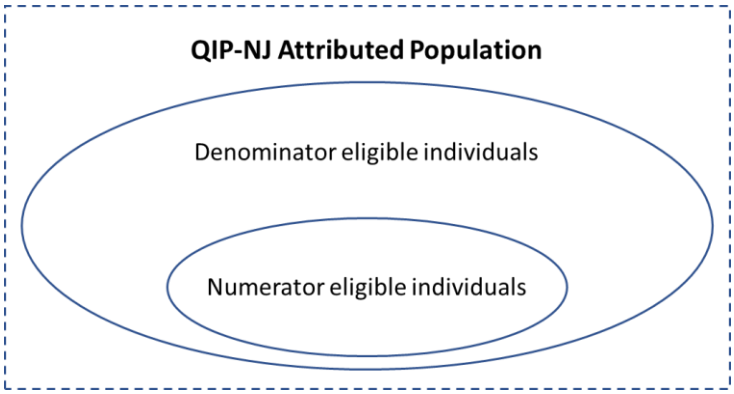

Figure 9. QIP-NJ Attributed Population for Chart/EHR measures

Step 1: The hospital receives the final retrospective attributed patient population list from the State.

Step 2: The hospital runs a query of their EHR system limited to searching for information about the attributed individuals only. This query always first includes looking for the measure-specific denominator eligibility criteria as outlined in measure specification and detailed by measure steward specifications.

For measures **not** using a sampling methodology:

> Step 3: The hospital reviews patient records to determine if numerator (N) compliance criteria have been met.

For measures using a sampling methodology:

> Step 3: The hospital compares the initial patient total to the sampling tables to determine the number of patient records that must be abstracted (refer to Section "Sampling Methodology" for information).
>
> Step 4: The hospital runs a standard random sampling query to select the specific patient records for abstraction.
>
> Step 5: The hospital reviews the sampled patient records to determine if numerator compliance criteria have been met.

Step 6: The hospital enters the initial patient total, numerator compliant and denominator compliant totals into the template or flat file. Formulas within the workbook will automatically calculate measure results.

L. Data Specification Conditions

i. MMIS Represented Data

The data made available for QIP-NJ performance measurement on state-selected quality measures is inclusive of paid claims for both Medicaid fee-for-service and managed care encounters.

ii. Performance Measure Calculation and Reporting Time Periods

Hospitals shall adhere to the measurement time periods identified in the specifications for each QIP-NJ state-selected quality measure. Several time periods affect performance measures, each of which will be updated for each applicable reporting year (MY1 has been included below for illustrative purposes):

a. Look-back Period – Some measures are indexed to a specific date or event (e.g., index date), such as a hospital admission or discharge, where the measure requires that a certain diagnosis be present within a defined prior period to the index event for the individual to be included in the population. This prior period is referred to as the look-back period.
b. Performance Period – Indicates the specific duration of time in which the dates of service must take place to be considered to meet measure criteria. This may be different from the MY. As an example, for measures where follow up must occur within 30 days, the last date of the performance period where the index visit may occur is December 1st, not December 31st which is the last day of the MY.
c. Reporting Period – The time-period for which the measure must be reported. QIP-NJ measures must be reported annually, unless otherwise specified. Each measure specification indicates the reporting period, as well as when the report is due to be reported by, or on the behalf of, the hospital.
d. Baseline Period – The time-period for which the first measurement will be computed. Future performance will then be compared against the baseline period. Each measure specification indicates the baseline period. For MMIS measures, 2020 data will be utilized to set the measures' QIP-NJ targets in later years. The baseline period for the majority of chart/EHR measures will utilize 2020 abstracted data unless otherwise noted.

iii. Eligible Population

Eligible populations for QIP-NJ includes all MMC enrolled individuals meeting the population criteria for maternal and/or behavioral health. For all measures, the eligible population is assigned to a hospital based on the program's attribution model (section "Attribution Methodology Overview"). The denominator is identified as a subset of these assigned individuals based upon meeting each measure's specific eligibility criteria. Certain measures have specific requirements surrounding continuous enrollment during the performance period. Continuous enrollment means that individuals are enrolled in health coverage with minimal gaps to keep them in the attributable population for maternal and/or behavioral health.

iv. Age Criteria

The age criterion is specific to each measure. For all behavioral health measures, the minimum age is 18. There are no such minimum criteria for maternal health. Measure specifications should always be consulted for specific age-related criteria. Age may be calculated as of the last day of the measurement period, except for BH07 and BH08 where it is calculated on the first day of the measurement period.

Measure results can be categorized into population age ranges to enable disaggregated reviews of clinical care outcomes for various age groups. Measure steward age stratifications were followed unless age ranges were considered too narrow or too broad to effectively address QIP-NJ priority population health improvement goals. When present, the age stratification that applies to P4P incentive payments will be the "Total" age group unless otherwise indicated.

v. Coding Guidance

a. Code Specificity – Appendix A has been updated to include Value Sets with the highest degree of specificity and should be used when calculating measure results. Within the Databook, the code tables within the measure specifications have been changed to code ranges where possible or are cited by name only.
b. Code Table Versions – National codes provided have been updated to the latest versions available, International Classification of Diseases (ICD)-10- Clinical Modification (CM) codes. For measures that have not been updated, ICD-10-CM codes were mapped (forward only from ICD- 9-CM to ICD- 10-CM) using the Agency for Healthcare Research and Quality (AHRQ) Map IT 2015 tool: http://www.qualityindicators.ahrq.gov/resources/Toolkits.aspx. Therefore, measure stewards that continue to use older versions will have been updated to reflect updated code sets. Although some exclusionary conditions require extensive lookback periods, inclusion of ICD-9-CM coded claim submissions is unlikely.
c. Code Use - Please note that the codes provided in the Databook are for quality analysis purposes only. These codes are published by the respective national measure stewards to determine measure results but may not reflect the care and/or billing practices of your organization.
d. The State is responsible for overseeing the proper calculation of measures for the program. Hospitals are responsible for submitting claims in accordance with NUBC / NUCC guidance and must submit non-claims-based data in accordance with the specifications for QIP-NJ. This includes but is not limited to:
    1. Code sets associated with institutional and professional billing (denoted as UB-04 and CMS-1500, respectively and borne out of primary reimbursement methodologies that are inpatient prospective payment and physician-fee-for-service) which may include:
        i. Type of bill
        ii. Place of service
        iii. Diagnostics
        iv. Procedures: (including ICD-10-PCS, UB Revenue codes, Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS Level II), modifiers)
        v. Provider type/taxonomy

2. Code sets that represent elements of an episode of care not traditionally reimbursed, including Logical Observation Identifiers Names and Codes (LOINC), among others.[6]

e. The State will not allow for modifications to measure specifications where hospital billing or clinical practices do not align with the way performance is measured under QIP-NJ.

vi. Claim Types

For both paper and electronic claim formats, the determination of what constitutes a claim is defined by National Billing Committees. Generalized guidelines are required on each claim to identify the type of service or type of bill represented by the submitted data. Certain bill types are designated by required data components which are utilized for the adjudication of the submitted claim, while other data components may be provided as a means of additional information only. The data elements required by the NJ Medicaid claim processing were identified through billing supplements and training documents located within the NJ MMIS website.

M. MMIS Measure Acknowledgment Process

MMIS data measure results will be made available to hospitals for viewing and export for all applicable reporting periods. Results files will be made available through the program's secure file transfer protocol (SFTP) (https://sftphealth.pcgus.com/) and accessed through each hospital's username and password authentication.

N. Measure Specification Description and Definitions

Each measure specification sheet is divided into four major sections.

1. The opening section provides high level references including the measure title, QIP-NJ number, measure description, data source, NQF number (if applicable), the measure steward and measure steward version (if applicable).
2. The second section includes the "Measure Calculation Description." This section provides information required to calculate the measure including its numerator, denominator, result information and any qualifications to the criteria that provide additional information.
3. The third section included the "Measure Collection Description" and provides fields related to the collection process. For example: the setting of care, reporting parameters or whether sampling, continuous eligibility or risk adjustment applies to the measure. This section also includes improvement target goal details (not included for Year 1) and identifies the financial incentive award as either non-payment or P4P. The "Data Elements" section flags key variables to note in the collection process.

[6] This is not an exhaustive listing of coding; consult the value sets per measure for further guidance.

II. Measurement Specifications: Behavioral Health Measure Set

A. Behavioral Health Measures Grid

Measure #	Measure Name and NQF #	Measure Steward	Data Source	State Baseline	VBP Reporting Years	Measure Weight
BH01	30 Day All-Cause Unplanned Readmission Following Psychiatric Inpatient Hospitalization- NQF #2860	CMS	MMIS	"Year 0" (7/1/2020-12/31/2020) claims data	Pay-for-performance in all years	11.11%
BH02	Follow-Up After Hospitalization for Mental Illness –30-days Post-Discharge- NQF #0576	NCQA	MMIS	"Year 0" (7/1/2020-12/31/2020) claims data	Pay-for-performance in all years	11.11%
BH03	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (30 day) – NQF #3488	NCQA	MMIS	"Year 0" (7/1/2020-12/31/2020) claims data	Pay-for-performance in all years	11.11%
BH04	Follow-Up After Emergency Department Visit for Mental Illness (30 day) – NQF #3489	NCQA	MMIS	"Year 0" (7/1/2020-12/31/2020) claims data	Pay-for-performance in all years	11.11%
BH05	Initiation of Alcohol and Other Drug Abuse or Dependence Treatment – NQF #0004	NCQA	MMIS	"Year 0" (7/1/2020-12/31/2020) claims data	Pay-for-performance in all years	11.11%
BH06	Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - NQF #0004	NCQA	MMIS	"Year 0" (7/1/2020-12/31/2020) claims data	Pay-for-performance in all years	11.11%
BH07	Preventative Care and Screening: Screening for Depression and	CMS	Chart/EHR	"Year 0" (7/1/2020-12/31/2020) Hospital	Pay-for-performance in all years	11.11%

	Follow-Up – NQF #0418			reported data		
BH08	Substance Use Screening and Intervention Composite – NQF #2597	ASAM	Chart/EHR	"Year 0" (7/1/2020-12/31/2020) Hospital reported data	Pay-for-performance in all years	11.11%
BH09	Timely Transmission of the Transition Record- NQF #0648	AMA-PCPI	Chart/EHR	"Year 0" (7/1/2020-12/31/2020) Hospital reported data	Pay-for-performance in all years	11.11%
BH10	3-Item Care Transitions Measure (CTM-3)	University of Colorado Denver Anschutz Medical Campus	Instrument	"Year 0" (7/1/2020-12/31/2020) Hospital reported data	Reporting only (Optional for MY5)	0%
BH11	Use of a Standardized Screening Tool for Social Determinants of Health	NJ DOH	Instrument	"Year 0" (7/1/2020-12/31/2020) Hospital reported data	Reporting only	0%
BH12	Reducing Disparities and Improving Patient Experience Through Targeted Training	NJ DOH	Training Records	"Year 0" (1/1/2022-12/31/2022) Hospital reported data	Reporting only	0%

Figure 10. Behavioral Health Measures Grid

Measure BH01: 30 Day All-Cause Unplanned Readmission Following Psychiatric Inpatient Hospitalization

Measure Description:
This measure calculates an unplanned, 30-day readmission rate for adults 18 to 64 years of age with a principal discharge diagnosis of a psychiatric disorder within a twelve-month period.

Data Source:	NQF #:
MMIS	**Based on 2860**
Measure Steward:	Measure Steward Version:
CMS	**June 12, 2019**

Statewide Target:
25%

Numerator:
A readmission is defined as any "unplanned" admission to an ACH. Hence, the numerator is defined by filtering out "always planned" and "potentially planned" diagnoses and procedures. It must occur within 3 to 30 days after the index discharge date from the eligible index admission date that had the principal discharge diagnosis of a psychiatric disorder.

Excludes:

- "Always planned" (Tables BH01_01, BH01_02), and "potentially planned" (Tables BH01_03) readmission diagnoses and procedures. The procedures are considered planned if they do not coincide with a principal discharge diagnosis of a psychiatric illness or complication that might necessitate the procedure (Table BH01_04).
- A subsequent admission on day of discharge and following 2 days (days 0, 1 and 2) due to transfers/interrupted stay period.

Denominator:
Of the hospital's attributed behavioral health population, eligible index admissions with a principal diagnosis of a psychiatric disorder (Table BH01_00).

This process defines planned readmissions based on criteria from the CMS 30-day Hospital-Wide All-Cause Readmission (HWR) Measure Planned Readmission Algorithm, version 4.0.[7] The implemented algorithm distinguishes two approaches that are used to identify planned readmissions.

For purposes of streamlining this measure, however, only "unplanned" readmissions (as observed counts) are factored into calculating the readmission rate. "Always planned" (Tables BH01_01, BH01_02) and

[7] 2020 HWR Readmission Measure Updates and Specifications Report

"potentially planned" (Tables BH01_03) readmissions are considered "exclusions". Therefore, to determine an unplanned readmission, the diagnosis or procedure must not specifically be listed within procedures or diagnoses listed within the tables.

Exclusions:
The denominator excludes admissions for individuals:

- "Always planned" (Tables BH01_01, BH01_02), and "potentially planned" (Tables BH01_03) readmission diagnoses and procedures. The procedures are considered planned if they do not coincide with a principal discharge diagnosis of a psychiatric illness or complication that might necessitate the procedure (Table BH01_04).
- Discharged against medical advice (AMA)
- With unreliable data (e.g., has a death date but also admissions afterwards)
- Missing age or gender

Result:
The result is expressed as a percentage.

Improvement Direction:
Lower

Data Elements:

- Attributed to the BH population
- Index admission date
- Principal discharge diagnosis
- Discharge disposition status
- Readmission date
- Readmission diagnosis(es) / procedure(s)

Measure Deviations from Original Specifications:

- The target population was changed to Medicaid from Medicare FFS
- Dementia / Alzheimer's disease is not included as a principal psychiatric discharge diagnosis
- The measure is not risk-adjusted based upon demographic data (e.g., gender, age) and principal diagnosis
- The numerator and denominator originally stated as "a readmission within 30 days"; this was changed to exclude readmissions on days 0 through 2
- The performance period used to identify cases in the denominator is 24 months; this is shortened in the revision to accommodate QIP-NJ's timeline

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances:

- https://www.qualityreportingcenter.com/globalassets/ipf-tools-andresources/ipf_cy2017_ipfqr_cbms_20171206_vfinal508.pdf
- http://www.qualityforum.org/QPS/2860

Measure Collection Description			
Setting of Care: **Inpatient**		Reporting Period: **Annual**	
Measurement Period: **January 1, 2025 – December 31, 2025**		Baseline Period: **July 1, 2020 –December 31, 2020**	
Payment Method: **P4P**		Measure Weight: **11.11%**	
Claim Type(s): **01, 14**	**01** – Inpatient Hospital **02** – Long Term Care **03** – Outpatient Hospital **04** – Physician **05** – Chiropractor **06** – Home Health **07** – Transportation **08** – Vision	**09** – Supplies, DME **10** – Podiatry **11** – Dental **12** – Pharmacy **13** – EPDST/Healthstart **14** – Institutional Crossover **15** – Professional Crossover	**16** – Lab **17** – Prosthetic and Orthotics **18** – Independent Clinic **19** – Psychologists **21** – Optometrists **22** – Mid Level Practitioner **23** – Hearing Aid
Continuous Eligibility Period: **Yes**	Risk Adjustment: **No**	Sampling: **No**	
Continuous Eligibility / Sampling Methodology: **The individual must be continuously enrolled from the date of discharge through 30 days after discharge without a gap in coverage to be eligible. Following, December 1 is the last day in the calendar year that an individual is eligible for consideration into this measurement cohort. No sampling permitted.**			

Measure BH02: Follow-up After Hospitalization for Mental Illness (FUH) – 30-Days Post-Discharge

Measure Description:
The percentage of discharges for individuals 18 to 64 years of age who were hospitalized for treatment of selected mental health disorders or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider within 30 days after discharge.

Data Source:	NQF #:
MMIS	**Based on 0576**
Measure Steward:	Measure Steward Version:
NCQA	**HEDIS® MY 2020 & MY 2021** **June 28, 2017**

Statewide Target:
75%

Measure Calculation Description

Numerator:
Individuals who received a mental health follow-up visit within 30 days after discharge. Does not include visits that occurred on the date of discharge.

Any one of the following meets the criteria for a mental health follow-up visit:

- For services provided by a hospital, individuals must have received a qualifying mental health follow up service (Table BH02_Nondx: Mental Health Follow-Up Revenue Value Set)
- For services provided in the community in the following settings (Table BH02_POS: NJ Place of Service Value Set):
    - Doctors Office (1)
    - Patient's Home (2)
    - Clinic (8); or
    - Other (9)

  Individuals must have received a qualifying mental health follow up service (Table BH02_Nondx: Mental Health Follow-Up CPT/HCPCS Value Set).

Denominator:
Of the hospital's attributed population, those individuals discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal diagnosis of mental illness, mental health diagnosis or intentional self-harm diagnosis (Table BH02_DetailOID: Follow-up After Hospitalization for Mental Illness (FUH) – 30 Days After Discharge) on or between January 1 and December 1 of the MY with continuous enrollment through 30 days post-discharge.

To identify acute inpatient discharges:

- Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
- Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).

- Identify the discharge date for the stay.

The denominator for this measure is based on discharges, not on individuals. If individuals have more than one discharge, include all discharges on or between January 1 and December 1 of the MY.

Identify readmissions and direct transfers to an acute inpatient care setting during the 30-day follow-up period:

- Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
- Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
- Identify the admission date for the stay.
- Exclude both the initial discharge and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the MY.
- If the readmission/direct transfer to the acute inpatient care setting was for a principal diagnosis (use only the principal diagnosis on the discharge claim) of mental health diagnosis, mental illness or intentional self-harm (Follow-up After Hospitalization for Mental Illness (FUH) – 30 Days After Discharge), count only the last discharge.
- If the readmission/direct transfer to the acute inpatient care setting was for any other principal diagnosis (use only the principal diagnosis on the discharge claim) exclude both the original and the readmission/direct transfer discharge.
- Exclude discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 30-day follow-up period, regardless of principal diagnosis for the readmission. (These discharges are excluded from the measure because rehospitalization or direct transfer may prevent an outpatient follow-up visit from taking place.) To identify readmissions and direct transfers to a nonacute inpatient care setting:
    - Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
    - Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
    - Identify the admission date for the stay.

Exclusions:

- Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
- Exclude both the initial discharge and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the MY.
- Exclude both the original and the readmission/direct transfer discharge if the readmission/direct transfer to the acute inpatient care setting was for any other principal diagnosis (use only the principal diagnosis on the discharge claim).
- Exclude discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 30-day follow-up period, regardless of principal diagnosis for the readmission.
- Exclude individuals receiving Adult Mental Health Rehabilitation (AMHR) within the same calendar month or calendar month subsequent to the index admission (Table BH02_AMHR: Adult Mental Health Rehabilitation (AMHR) Value Set).
- Exclude if used hospice during the measurement period (Hospice Encounter, Hospice Intervention Value Set).
- Exclude individuals under age 18 or over age 64 at time of initial admission.
- Exclude individuals who expired during their stay

- Exclude individuals who are incarcerated, as indicated by a discharge status code.
- Exclude discharges for discharge/transfer to an inpatient psychiatric setting denoted with Discharge Status Code 65
- Exclude discharges for discharge/transfer to a short-term facility/general hospital for inpatient care denoted with Discharge Status Code 02

Result:
The result is expressed as a percentage.

Improvement Direction:
Higher

Measure Deviations from Original Specifications:

- Limited to individuals aged 18 -64.
- Deleted from the numerator: Mental Health Practitioner Value Set, which removed the mental health provider requirement for follow-up visits; mental health services are identified using the Mental Health Fee-for-Service Program Provider Manual (Version 4.8.2, January 2021).
- Deleted values sets: Ambulatory Surgical Center POS, Behavioral Healthcare Setting, BH Outpatient, Community Mental Health Center POS, Electroconvulsive Therapy, Observation, Outpatient POS, Partial Hospitalization or Intensive Outpatient, Partial Hospitalization POS.
- Two rates, one for 30 day and 7 day, are traditionally reported; only the 30 day is required.

Major Changes HEDIS MY 2022:

- Provided updated steps for identifying acute readmission or direct transfer in the event/diagnosis. Clarified that nonacute readmission or direct transfer discharges are excluded because they may prevent an outpatient follow-up from taking place.

Data Elements:

- Attributed to the BH population
- Place of Service (020300 2021 NJMMIS Quick Guide)
- Mental Health Outpatient Billing (Revenue, CPT, HCPCS) Code
- Index admission date
- Principal discharge diagnosis
- Discharge disposition status
- Follow up visit category
- Follow up visit date
- Readmission date (if applicable)

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances:

- http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures.aspx
- http://www.qualityforum.org/QPS/0576

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Multi-setting (see claim types below)</td><td colspan="3">Reporting Period:
Annual</td></tr>
<tr><td colspan="2">Measurement Period:
January 1, 2025 – December 31, 2025</td><td colspan="3">Baseline Period:
July 1, 2020 – December 31, 2020</td></tr>
<tr><td colspan="2">Payment Method:
P4P</td><td colspan="3">Measure Weight:
11.11%</td></tr>
<tr><td>Claim Type(s):

01, 03, 04, 06, 14, 15, 18, 19, 22</td><td>01 – Inpatient Hospital
02 – Long Term Care
03 – Outpatient Hospital
04 – Physician
05 – Chiropractor
06 – Home Health
07 – Transportation
08 – Vision</td><td>09 – Supplies, DME
10 – Podiatry
11 – Dental
12 – Pharmacy
13 – EPDST/Healthstart
14 – Institutional Crossover
15 – Professional Crossover</td><td colspan="2">16 – Lab
17 – Prosthetic and Orthotics
18 – Independent Clinic
19 – Psychologists
21 – Optometrists
22 – Mid Level Practitioner
23 – Hearing Aid</td></tr>
<tr><td colspan="2">Continuous Eligibility Period: Yes</td><td colspan="2">Risk Adjustment: No</td><td>Sampling: No</td></tr>
<tr><td colspan="5">Continuous Eligibility / Sampling Methodology: The individual must be continuously enrolled from the date of discharge through 30 days after discharge without a gap in coverage to be eligible. Following, December 1 is the last day in the calendar year that an individual is eligible for consideration into this measurement cohort. No sampling is permitted.</td></tr>
</table>

Measure BH03: Follow-Up After Emergency Department (ED) Visit for Substance Use (FUA-AD) (30 day)

Measure Description:
The percentage of discharges for individuals 18 to 64 years of age who had a visit to the ED with a principal diagnosis of substance use disorder (SUD) during the MY AND who had a SUD treatment follow-up visit with any provider within 30-days of discharge (31 total days).

Data Source:	NQF #:
MMIS	**Based on 3488**
Measure Steward:	Measure Steward Version:
NCQA	**HEDIS® 2020 & MY 2021 October 4, 2019**

Statewide Target:
25%

Measure Calculation Description

Numerator:
An SUD use treatment follow-up visit (AOD Treatment Service Follow-up CPT/HCPCS Value Set) with any provider, within 30 days (31 total days) after emergency department discharge with a principal diagnosis of SUD. Include visits that occur on the date of the ED visit. Claims must have the appropriate modifiers to indicate substance use treatment services, as identified in the AOD Treatment Value Set.

Any one of the following meets the criteria for an SUD follow-up visit:

- For services provided in the community in the following settings (NJ Place of Service Value Set):
  - Outpatient Hospital (7 or bill type 13x)

  Individuals must have received a qualifying SUD follow up service (AOD Treatment Service Follow-up CPT/HCPCS Value Set)
- For services provided in the community in the following settings (NJ Place of Service Value Set):
  - Doctors Office (1)
  - Patient's Home (2)
  - Clinic (8 or bill type 72x); or
  - Other (9)

Individuals must have received a qualifying SUD follow up service (AOD Treatment Service Follow-up CPT/HCPCS Value Set).

Denominator:
An ED visit (BH03_DetailOID->ED Value Set) with a principal diagnosis of SUD (BH03_DetailOID-> AOD Abuse and Dependence Value Set) on or between January 1 and December 1 of the MY where the individual was 18 years of age through 64 years of age on the date of the visit.

The denominator for this measure is based on ED visits, not on individuals. If an individual has more than one ED visit, identify all eligible ED visits between January 1 and December 1 of the MY and do not include more than one visit per 31-day period, as described below.

If an individual has more than one ED visit in a 31-day period, include only the first eligible ED visit. For example, if an individual has an ED visit on January 1, include the January 1 visit and do not include ED visits that occur on or between January 2 and January 31; then, if applicable, include the next ED visit that occurs on or after February 1. Identify visits chronologically, including only one per 31-day period.

Note: Removal of multiple visits in a 31-day period is based on eligible visits. Assess each ED visit for exclusions before removing multiple visits in a 31-day period.

Exclusions:

- Exclude if the ED visit results in an observation (Observation Value Set).
- Exclude ED visits that result in an inpatient stay (Inpatient Stay Value Set) and ED visits followed by an admission to an acute or nonacute inpatient care setting (Nonacute Inpatient Stay Value Set) on the date of the ED visit or within the 30 days after the ED visit, regardless of the principal diagnosis for the admission. To identify admissions to an acute or nonacute inpatient care setting: Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). Identify the admission date for the stay. These events are excluded from the measure because admission to an acute or nonacute inpatient setting may prevent an outpatient follow-up visit from taking place.
- Exclude if the ED visit/discharge is followed by readmission or direct transfer to another ED for a principal diagnosis of SUD within the 30-day follow-up period, count only the ED revisit to which the individual was transferred.
- Exclude if an ED visit results in discharge/transfer to an inpatient psychiatric setting denoted with Discharge Status Code 65
- Exclude if an ED visit results in discharge/transfer to a short-term facility/general hospital for inpatient care denoted with Discharge Status Code 02
- Exclude ED visits followed by admission or direct transfer to an acute or nonacute facility (Inpatient Stay Value Set) within the 30-day follow-up period, regardless of principal diagnosis for the admission.
    - These discharges are excluded from the measure because hospitalization or transfer may prevent an outpatient follow-up visit from taking place.
- Exclude if individual used hospice during the measurement period (Hospice Encounter, Hospice Intervention Value Set).
- Exclude individuals who are incarcerated, as indicated by a discharge status code

Result:
Percentage

Improvement Direction:
Higher

Measure Deviations from Original Specifications:

- Limited to individuals aged 18-64.
- Deleted values sets: IET Stand Alone Visits, OUD Weekly Non-Drug Service, OUD Monthly Office Based Treatment, IET Visits Group 1 and Group 2, Online Assessments.
- Added in an AOD Treatment Service Follow-up CPT/HCPCS Value Set based on NJ MMIS billing codes.
- Two rates, one for 30 day and 7 day, are traditionally reported; only the 30 day is required.

Major Changes HEDIS MY 2022:

- Revised the measure name from Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence to Follow-Up After Emergency Department Visit for Substance Use.
- Replaced "alcohol and other drug (AOD)" references with "substance use disorder (SUD)"

Data Elements:

- Attributed to the BH population
- Place of Service (020300 2021 NJMMIS Quick Guide)
- AOD Treatment Service Follow-up CPT/HCPCS Value Set
- Index admission date
- Principal discharge diagnosis
- Discharge disposition status
- Follow up visit billing (Revenue, CPT, HCPCS) code
- Follow up visit date

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances:

- http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures.aspx
- http://www.qualityforum.org/QPS/3488

Measure Collection Description

<table>
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Multi-setting (see claim types below)</td><td colspan="2">Reporting Period:
Annual</td></tr>
<tr><td colspan="2">Measurement Period:
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18 – Independent Clinic
19 – Psychologists
21 – Optometrists
22 – Mid Level Practitioner
23 – Hearing Aid</td></tr>
<tr><td colspan="2">Continuous Eligibility Period: Yes</td><td>Risk Adjustment: No</td><td>Sampling: No</td></tr>
<tr><td colspan="4">Continuous Eligibility / Sampling Methodology: The individual must be continuously enrolled from the date of discharge through 30 days after discharge without a gap in coverage to be eligible. Following, December 1 is the last day in the calendar year that an individual is eligible for consideration into this measurement cohort. No sampling permitted.</td></tr>
</table>

Measure BH04: Follow-Up After ED Visit for Mental Illness (FUM) (30 day)

Measure Description:
The percentage of discharges for individuals 18 to 64 years of age who had a visit to the emergency department with a principal diagnosis of mental health or intentional self-harm during the MY and who had a follow-up visit for mental illness within 30-days of discharge (31 total days).

Data Source:	NQF #:
MMIS	**Based on 3489**
Measure Steward:	Measure Steward Version:
NCQA	**HEDIS® MY 2020 & MY 2021 October 24, 2019**

Statewide Benchmark:
75%

Measure Calculation Description

Numerator:
Individuals who received a mental health follow-up visit within 30 days after ED visit (31 total days). Includes visits that occur on the date of the ED visit.

Any one of the following meets the criteria for a mental health follow-up visit:

- For services provided by a hospital, individuals must have received a qualifying mental health follow up service (Table BH04_Nondx: Mental Health Follow-Up Revenue Value Set)
- For services provided in the community in the following settings (Table BH04_POS: NJ Place of Service Value Set):
    - Doctors Office (1)
    - Patient's Home (2)
    - Clinic (8); or
    - Other (9)

  Individuals must have received a qualifying mental health follow up service (Table BH04_Nondx: Mental Health Follow-Up CPT/HCPCS Value Set).

Denominator:
Individuals who were treated and discharged from an ED with a principal diagnosis of mental illness or intentional self-harm on or between January 1 and December 1 of the MY.

An ED visit (ED Value Set) with a principal diagnosis of mental illness or intentional self-harm (Mental Illness Value Set; Mental Health Diagnosis; Intentional Self-Harm Value Set) on or between January 1 and December 1 of the MY where the individual was 18 years of age through 64 years of age on the date of the visit.

The denominator for this measure is based on ED visits, not on individuals. If an individual has more than one ED visit, identify all eligible ED visits between January 1 and December 1 of the MY and do not include more than one visit per 31-day period as described below.

If an individual has more than one ED visit in a 31-day period, include only the first eligible ED visit. For example, if an individual has an ED visit on July 1, include the July 1 visit and do not include ED visits that occur on or between July 2 and July 31; then, if applicable, include the next ED visit that occurs on or after August 1. Identify visits chronologically, including only one per 31-day period.

Note: Removal of multiple visits in a 31-day period is based on eligible visits. Assess each ED visit for exclusions before removing multiple visits in a 31-day period.

Exclusions:

- Exclude ED visits that result in an inpatient stay and ED visits followed by an admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit (31 total days), regardless of the principal diagnosis for the admission. To identify admissions to an acute or nonacute inpatient care setting:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Identify the admission date for the stay.

     These events are excluded from the measure because admission to an acute or nonacute inpatient setting may prevent an outpatient follow-up visit from taking place.
- Exclude ED visits/discharges followed by admission or direct transfer to an acute or nonacute facility (Inpatient Stay Value Set) or as denoted by Discharge Status Code 65 or 02 within the 30-day follow-up period, regardless of principal diagnosis for the admission.
  - These discharges are excluded from the measure because hospitalization or transfer may prevent an outpatient follow-up visit from taking place.
- Exclude if used hospice during the measurement period (Hospice Encounter, Hospice Intervention Value Set).
- Exclude individuals receiving Adult Mental Health Rehabilitation (AMHR) within the same calendar month or calendar month subsequent to the index admission (Table BH04_AMHR: Adult Mental Health Rehabilitation (AMHR) Value Set).
- Exclude individuals who are incarcerated, as indicated by a discharge status code.

Result:
Percentage

Improvement Direction:
Higher

Measure Deviations from Original Specifications:

- Added telephone visits, e-visits and virtual check-ins to the numerator.

- Measure description for individuals 6 years of age and older; only individuals 18 years of age and older are included for QIP-NJ.
- Deleted from the numerator: Mental Health Practitioner Value Set, which removed the mental health provider requirement for follow-up visits; mental health services are identified using the Mental Health Fee-for-Service Program Provider Manual (Version 4.8.2, January 2021). Two rates, one for 30 day and 7 day, are traditionally reported; only the 30 day is required.

Data Elements:

- Attributed to the BH population
- Principal discharge diagnosis
- Discharge date
- Discharge disposition status
- Follow up visit billing (Revenue, CPT, HCPCS) code
- Follow up visit date
- Readmission date (if applicable)

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances:

- http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures.aspx
- http://www.qualityforum.org/QPS/3489

<table>
<tr><th colspan="5">Measure Collection Description</th></tr>
<tr><td colspan="2">Setting of Care:
Multi-setting (see claim types below)</td><td colspan="3">Reporting Period:
Annual</td></tr>
<tr><td colspan="2">Measurement Period:
January 1, 2025 – December 31, 2025</td><td colspan="3">Baseline Period:
July 1, 2020 –December 31, 2020</td></tr>
<tr><td colspan="2">Payment Method:
P4P</td><td colspan="3">Measure Weight:
11.11%</td></tr>
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03, 04, 06, 14, 15, 18, 19, 22</td><td>01 – Inpatient Hospital
02 – Long Term Care
03 – Outpatient Hospital
04 – Physician
05 – Chiropractor
06 – Home Health
07 – Transportation
08 – Vision</td><td>09 – Supplies, DME
10 – Podiatry
11 – Dental
12 – Pharmacy
13 – EPDST/Healthstart
14 – Institutional Crossover
15 – Professional Crossover</td><td colspan="2">16 – Lab
17 – Prosthetic and Orthotics
18 – Independent Clinic
19 – Psychologists
21 – Optometrists
22 – Mid Level Practitioner
23 – Hearing Aid</td></tr>
<tr><td colspan="2">Continuous Eligibility Period: Yes</td><td colspan="2">Risk Adjustment: No</td><td>Sampling: No</td></tr>
<tr><td colspan="5">Continuous Eligibility / Sampling Methodology: Individuals must be continuously enrolled from the date of discharge through 30 days after discharge without a gap in coverage to be eligible. Following, December 1 is the last day in the calendar year that an individual is eligible for consideration into this measurement cohort. No sampling permitted.</td></tr>
</table>

Measure BH05: Initiation of Alcohol and Other Drug Abuse or Dependence Treatment (IET – I)

Measure Description:
The percentage of individuals 18 to 64 years of age with a new episode of substance use disorder (SUD) who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the diagnosis.

Data Source:	NQF #:
MMIS	**Based on 0004**
Measure Steward:	Measure Steward Version:
NCQA	**HEDIS® MY 2020 & MY 2021** **June 10, 2019**
Statewide Benchmark:	
73%	

Measure Calculation Description

Definitions:

Intake Period	January 1–November 14 of the MY. The Intake Period is used to capture new episodes of SUD
Index Episode	The earliest eligible encounter during the Intake Period with a diagnosis of SUD. *For ED or observation visits that result in an inpatient stay*, the inpatient discharge is the index episode.
Date of service for services billed weekly or monthly	For an opioid treatment service that bills monthly or weekly (Table BH0506M05_IET_DetailOID: IET Master Table > OUD Weekly Non-Drug Service Value Set; OUD Monthly Office Based Treatment Value Set; OUD Weekly Drug Treatment Service Value Set), if the service includes a range of dates, then use the earliest date as the date of service. Use this date for all relevant events (the IESD, negative diagnosis history and numerator events).
IESD	Index Episode Start Date. The earliest date of service for an eligible encounter during the Intake Period with a diagnosis of SUD. *For an outpatient, intensive outpatient, partial hospitalization, observation, telehealth, or ED visit (not resulting in an inpatient stay),* the IESD is the date of service. *For an inpatient stay or for detoxification that occurred during an inpatient stay,* the IESD is the date of discharge. *For detoxification* (other than detoxification that occurred during an inpatient stay), the IESD is the date of service. *For ED or observation visits that result in an inpatient stay,* the IESD is the date of the inpatient discharge (an SUD diagnosis is not required for the inpatient stay; use the diagnosis from the ED or observation visit to determine the diagnosis cohort).

	For direct transfers, the IESD is the discharge date from the last admission (an SUD diagnosis is not required for the transfer; use the diagnosis from the initial admission to determine the diagnosis cohort).
Negative Diagnosis History	A period of 60 days (2 months) before the IESD when the individual had no claims/encounters in any setting other than an ED visit or a medically managed withdrawal event with a diagnosis of SUD. *For an inpatient stay,* use the admission date to determine the Negative Diagnosis History. *For ED or observation visits that result in an inpatient stay,* use the earliest date of service (either the ED/observation date of service or the inpatient admission date) to determine the Negative Diagnosis History. *For direct transfers,* use the first admission to determine the Negative Diagnosis History.
Direct transfer	A direct transfer is when the discharge date from the first inpatient setting precedes the admission date to a second inpatient setting by one calendar day or less. For example: An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1, is a direct transfer. An inpatient discharge on June 1, followed by an admission to an inpatient setting on June 2, is a direct transfer. An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 3, is not a direct transfer; these are two distinct inpatient stays. Use the following method to identify admissions to and discharges from inpatient settings. 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the admission and discharge dates for the stay.

Numerator:
Individuals who have initiation of SUD treatment within 14 days of the Index Episode (IESD).

- If the IESD was an inpatient discharge (or an ED/observation visit that resulted in an inpatient stay), the inpatient stay is considered initiation of treatment and the individual is compliant.
- If the IESD was an opioid treatment service that bills monthly (OUD Monthly Office Based Treatment Value Set), the opioid treatment service is considered initiation of treatment and the individual is compliant.
- If the IESD was not an inpatient discharge, the individual must initiate treatment on the IESD or in the 13 days after the IESD (14 total days). Any of the following code combinations meet criteria for initiation:
    - An acute or nonacute inpatient admission with a diagnosis (on the discharge claim) matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute and nonacute inpatient admissions:
        - Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).

    - Identify the admission date for the stay.
- IET Stand Alone Visits Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- Observation Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- IET Visits Group 1 Value Set with IET POS Group 1 Value Set and a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- IET Visits Group 2 Value Set with IET POS Group 2 Value Set and a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A telephone visit (Telephone Visit Value Set) with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An e-visit or virtual check-in (Online Assessments Value Set) with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- If the IESD was for a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set) an opioid treatment service (OUD Weekly Non-Drug Service Value Set).
- If the Index Episode was for a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set) an opioid treatment service (OUD Monthly Office Based Treatment Value Set).
- If the IESD was for a diagnosis of alcohol abuse or dependence (Alcohol Abuse and Dependence Value Set) a medication treatment dispensing event (Alcohol Use Disorder Treatment Medications List) or medication treatment during a visit (AOD Medication Treatment Value Set).
- If the IESD was for a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set) a medication treatment dispensing event (Opioid Use Disorder Treatment Medications List) or medication treatment during a visit (AOD Medication Treatment Value Set; OUD Weekly Drug Treatment Service Value Set).
- For all initiation events except medication treatment (AOD Medication Treatment Value Set; Alcohol Use Disorder Treatment Medications List; Opioid Use Disorder Treatment Medications List), initiation on the same day as the IESD must be with different providers in order to count.
- If an individual is compliant for the Initiation numerator for any diagnosis cohort (alcohol, opioid, other drug) or for multiple cohorts, count the individual only once in the Total Initiation numerator. The “Total” column is not the sum of the diagnosis columns.
- Exclude the individual from the denominator for both indicators (Initiation of AOD Treatment and Engagement of AOD Treatment) if the initiation of treatment event is an inpatient stay with a discharge date after November 27 of the MY.

Denominator:
Individuals with a new episode of substance use disorder (SUD) during the Intake Period.

Follow the steps below to identify the eligible population, which is the denominator.

Step 1: Identify the Index Episode. Identify all individuals in the specified age range who during the Intake Period had one of the following:

- An outpatient visit, telehealth, intensive outpatient visit or partial hospitalization with a diagnosis of SUD. Any of the following code combinations meet criteria:
    1. IET Stand Alone Visits Value Set with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
    2. IET Visits Group 1 Value Set with IET POS Group 1 Value Set and with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
    3. IET Visits Group 2 Value Set with IET POS Group 2 Value Set and with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
    4. OUD Weekly Non-Drug Service Value Set with Opioid Abuse and Dependence Value Set.
    5. OUD Monthly Office Based Treatment Value Set with Opioid Abuse and Dependence Value Set.
    6. OUD Weekly Drug Treatment Service Value Set with Opioid Abuse and Dependence Value Set.
- A detoxification visit (Detoxification Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An ED visit (ED Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An observation visit (Observation Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An acute or nonacute inpatient discharge with one of the following on the discharge claim: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute and nonacute inpatient discharges:
    1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
    2. Identify the discharge date for the stay.
- A telephone visit (Telephone Visits Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An e-visit or virtual check-in (Online Assessments Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An opioid treatment service (OUD Weekly Non-Drug Service Value Set; OUD Monthly Office Based Treatment Value Set; OUD Weekly Drug Treatment Service Value Set) with a diagnosis of opioid abuse of dependence (Opioid Abuse and Dependence Value Set).

For individuals with more than one episode of SUD, use the first episode.

For individuals whose first episode was an ED or observation visit that resulted in an inpatient stay, use the diagnosis from the ED or observation visit to determine the diagnosis cohort and use the inpatient discharge date as the IESD.

Step 2: Select the Index Episode and stratify based on age and SUD diagnosis cohort.

- If the individual has a diagnosis of alcohol abuse or dependence (Alcohol Abuse and Dependence Value Set), place the individual in the alcohol cohort.
- If the individual has a diagnosis of opioid abuse of dependence (Opioid Abuse and Dependence Value Set), place the individual in the opioid cohort.
- If the individual has a drug abuse or dependence that is neither for opioid or alcohol (Other Drug Abuse and Dependence Value Set), place the individual in the other drug cohort.

If the individual has multiple substance use diagnosis for the visit, report the individual in all SUD diagnosis stratifications for which they meet criteria.

The total is not a sum of the diagnosis cohorts. Count individuals in the total denominator rate if they had at least one alcohol, opioid or other drug abuse or dependence diagnosis during the measurement period. Report individual with multiple diagnoses during the Index Episode only once for the total rate for the denominator.

Step 3: Test for Negative Diagnosis History. Exclude individuals who had a claim/encounter in any setting other than an ED visit (ED Value Set) or a medically managed withdrawal (i.e., detoxification) event (Detoxification Value Set) with a diagnosis of SUD (AOD Abuse and Dependence Value Set), SUD medication treatment (AOD Medication Treatment Value Set) or an substance use disorder treatment medication dispensing event (Alcohol Use Disorder Treatment Medications List; Opioid Use Disorder Treatment Medications List) during the 60 days (2 months) before the IESD.

For an inpatient IESD, use the admission date to determine the 60-day Negative Diagnosis History period.

For ED or observation visits that result in an inpatient stay, use the earliest date of service (either the ED/observation date of service or the inpatient admission date) to determine the Negative Diagnosis History.

Step 4: Calculate continuous enrollment. Individuals must be continuously enrolled for 60 days (2 months) before the IESD through 47 days after the IESD (108 total days), with no gaps.

Exclusions:

- Exclude individuals who had a claim/encounter with a diagnosis of SUD (AOD Abuse and Dependence Value Set), SUD medication treatment (AOD Medication Treatment Value Set) or substance use disorder dependency treatment medication dispensing event (Alcohol Use

Disorder Treatment Medications List; Opioid Use Disorder Treatment Medications List) during the 60 days (2 months) before the IESD.

- Exclude if used hospice during the measurement period (Hospice Encounter, Hospice Intervention Value Set).

Result:
The result is expressed as a percentage.

Improvement Direction:
Higher

Measure Deviations from Original Specifications:

- The measure steward age stratifies the results by 13-17, 18+ and a Total. Only the age stratification that includes all ages (Total) will be used for QIP-NJ.
- Limited measure to individuals aged 18-64.
- In 2018 the measure steward began stratifying by SUD diagnosis cohort, alcohol abuse or dependence, opioid abuse or dependence, other drug abuse or dependence and total. Payment will not be impacted by performance across these stratifications.

Major Changes HEDIS MY 2020 and MY 2021:

- Clarified the Episode Date when detoxification occurs during an acute inpatient stay.
- Updated the step 3 instructions for ED and observation visits that result in an inpatient stay, to make them consistent with instructions in the Definitions section.
- Added value sets for opioid treatment services that are billed weekly or monthly to the denominator and numerators.
- Updated the continuous enrollment period.

Major Changed HEDIS MY 2022:

- Replaced “alcohol and other drug (AOD)” references with “substance use disorder (SUD)”
- Revised Negative Diagnosis Criteria

Data Elements:

- Attributed to the BH population
- Index episode
- Admission date
- Follow up visit category
- Follow up visit date

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances:

- http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures.aspx
- http://www.qualityforum.org/QPS/0004

<table>
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<tr><td colspan="2">Measurement Period:
January 1, 2025 – December 31, 2025</td><td colspan="3">Baseline Period:
July 1, 2020 – December 31, 2020</td></tr>
<tr><td colspan="2">Payment Method:
P4P</td><td colspan="3">Measure Weight:
11.11%</td></tr>
<tr><td>Claim Type(s):

01, 03, 04, 14, 15, 18, 19</td><td>01 – Inpatient Hospital
02 – Long Term Care
03 – Outpatient Hospital
04 – Physician
05 – Chiropractor
06 – Home Health
07 – Transportation
08 – Vision</td><td>09 – Supplies, DME
10 – Podiatry
11 – Dental
12 – Pharmacy
13 – EPDST/Healthstart
14 – Institutional Crossover
15 – Professional Crossover</td><td colspan="2">16 – Lab
17 – Prosthetic and Orthotics
18 – Independent Clinic
19 – Psychologists
21 – Optometrists
22 – Mid Level Practitioner
23 – Hearing Aid</td></tr>
<tr><td colspan="2">Continuous Eligibility Period: Yes</td><td colspan="2">Risk Adjustment: No</td><td>Sampling: No</td></tr>
<tr><td colspan="5">Continuous Eligibility / Sampling Methodology: Individuals must be continuously enrolled without any gaps 60 days (2 months) before the IESD through 48 days after the IESD. Following, November 13 is the last day in the calendar year that an individual is eligible for consideration into this measurement cohort. No sampling permitted.</td></tr>
</table>

Measure BH06: Engagement in Alcohol and Other Drug Abuse or Dependence Treatment (IET – E)

Measure Description:
The percentage of individuals 18 to 64 years of age who initiated treatment and who were engaged in ongoing SUD treatment within 34 days of the initiation visit.

Data Source:	NQF #:
MMIS	**Based on 0004**
Measure Steward:	Measure Steward Version:
NCQA	**HEDIS® MY 2020 & MY 2021** **June 10, 2019**
Statewide Benchmark:	
40%	

Measure Calculation Description

Definitions:

Intake Period **January 1–November 14 of the MY.**

Numerator:
Individuals who have engagement of SUD treatment after the initiation encounter within 34 days (total of 34 days) of the index event (IESD).

Step 1 Identify all individuals compliant for the Initiation of SUD Treatment numerator.

For individuals who initiated treatment via an inpatient admission, the 34-day period for engagement begins the day after discharge.

Step 2 Identify individuals who had an opioid treatment service that bills monthly (OUD Monthly Office Based Treatment Value Set) or who had a visit that included medication administration (OUD Weekly Drug Treatment Service Value Set) beginning on the day after the initiation encounter through 34 days after the initiation event.

For these individuals, if the IESD Diagnosis cohort was a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set), the individual is numerator compliant for Engagement of SUD Treatment.

Step 3 Identify individuals whose initiation of SUD treatment was a medication treatment event (Alcohol Use Disorder Treatment Medications List; Opioid Use Disorder Treatment Medications List; AOD Medication Treatment Value Set).

These individuals are numerator compliant if they have two or more engagement events, where only one can be an engagement medication treatment event,

beginning on the day after the initiation encounter through 34 days after the initiation event (total of 34 days).

Step 4 Identify the remaining individuals whose initiation of SUD treatment was *not* a medication treatment event (individuals not identified in step 3).

These individuals are numerator compliant if they meet *either* of the following:

- At least one engagement medication treatment event.
- At least two engagement visits.

Two engagement visits can be on the same date of service but they must be with different providers in order to count as two events. An engagement visit on the same date of service as an engagement medication treatment event meets criteria (there is no requirement that they be with different providers).

Refer to the descriptions below to identify engagement visits and engagement medication treatment events.

Engagement visits Any of the following beginning on the day after the initiation encounter through 34 days after the initiation event (total of 34 days) meet criteria for an engagement visit:

- An acute or nonacute inpatient admission with a diagnosis (on the discharge claim) matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute or nonacute inpatient admissions:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Identify the admission date for the stay.
- IET Stand Alone Visits Value Set ***with*** a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- Observation Value Set ***with*** a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- IET Visits Group 1 Value Set ***with*** IET POS Group 1 Value Set ***with*** a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- IET Visits Group 2 Value Set ***with*** IET POS Group 2 Value Set ***with*** a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.

- A telephone visit (Telephone Visits Value Set) ***with*** a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An e-visit or virtual check-in (Online Assessments Value Set) ***with*** a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- If the IESD Diagnosis cohort was a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set) an opioid treatment service (OUD Weekly Non-Drug Service Value Set).

Engagement medication treatment events

Either of the following meets criteria for an engagement medication treatment event:

- If the IESD diagnosis was *a diagnosis of alcohol abuse or dependence* (Alcohol Abuse and Dependence Value Set), one or more medication treatment dispensing events (Alcohol Use Disorder Treatment Medications List) or medication treatment during a visit (AOD Medication Treatment Value Set), beginning on the day after the initiation encounter through 34 days after the initiation event (total of 34 days), meets criteria for Alcohol Abuse and Dependence Treatment.
- If the IESD diagnosis was *a diagnosis of opioid abuse or dependence* (Opioid Abuse and Dependence Value Set), one or more medication dispensing events (Opioid Use Disorder Treatment Medications List) or medication treatment during a visit (AOD Medication Treatment Value Set), beginning on the day after the initiation encounter through 34 days after the initiation event (total of 34 days), meets criteria for Opioid Abuse and Dependence Treatment.

If the individual is compliant for multiple cohorts, only count the individual once for the Total Engagement numerator. The Total column is not the sum of the Diagnosis columns.

Alcohol Use Disorder Treatment Medications List

Description	Prescription
Aldehyde dehydrogenase inhibitor	• Disulfiram (oral)
Antagonist	• Naltrexone (oral and injectable)
Other	• Acamprosate (oral; delayed-release tablet)

Opioid Use Disorder Treatment Medications List

Description	Prescription
Agonist	• Methadone (oral dispensation in ED or inpatient admission)
Antagonist	• Naltrexone (oral and injectable)
Partial agonist	• Buprenorphine (sublingual tablet, injection, implant) • Buprenorphine/naloxone (sublingual tablet, buccal film, sublingual film)

- For individuals in the "other drug abuse or dependence" cohort, medication treatment does not meet numerator criteria for Initiation of SUD Treatment or Engagement of SUD Treatment.
- Given the increased prevalence and concentration of fentanyl, some hospitals have transitioned to medication-based treatment to include a combination of either methadone or buprenorphine in treating substance use patients. These treatments may be initiated in the ED and/or during inpatient admission.

Denominator:
Individuals with a new episode of SUD abuse or dependence during the Intake Period.

Follow the steps below to identify the eligible population, which is the denominator.

Step 1: Identify the IESD. Identify all individuals in the specified age range who during the Intake Period had one of the following:

- An outpatient visit, telehealth, intensive outpatient visit or partial hospitalization with a diagnosis of SUD.
- Any of the following code combinations meet criteria:
    - IET Stand Alone Visits Value Set with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
    - IET Visits Group 1 Value Set with IET POS Group 1 Value Set and with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
    - IET Visits Group 2 Value Set with IET POS Group 2 Value Set and with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
    - OUD Weekly Non-Drug Service Value Set with Opioid Abuse and Dependence Value Set.
    - OUD Monthly Office Based Treatment Value Set with Opioid Abuse and Dependence Value Set.
    - OUD Weekly Drug Treatment Service Value Set with Opioid Abuse and Dependence Value Set.
- A detoxification visit (Detoxification Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.

- An ED visit (ED Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An observation visit (Observation Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An acute or nonacute inpatient discharge with one of the following on the discharge claim: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute and nonacute inpatient discharges:
    1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
    2. Identify the discharge date for the stay.
- A telephone visit (Telephone Visits Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An e-visit or virtual check-in (Online Assessments Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An opioid treatment service (OUD Weekly Non-Drug Service Value Set; OUD Monthly Office Based Treatment Value Set; OUD Weekly Drug Treatment Service Value Set) with a diagnosis of opioid abuse of dependence (Opioid Abuse and Dependence Value Set).

For individuals with more than one episode of SUD, use the first episode.

For individuals whose first episode was an ED or observation visit that resulted in an inpatient stay, use the diagnosis from the ED or observation visit to determine the diagnosis cohort and use the inpatient discharge date as the IESD.

Step 2: Select the Index Episode and stratify based on age and SUD diagnosis cohort.

- If the individual has a diagnosis of alcohol abuse or dependence (Alcohol Abuse and Dependence Value Set), place the individual in the alcohol cohort.
- If the individual has a diagnosis of opioid abuse of dependence (Opioid Abuse and Dependence Value Set), place the individual in the opioid cohort.
- If the individual has a drug abuse or dependence that is neither for opioid or alcohol (Other Drug Abuse and Dependence Value Set), place the individual in the other drug cohort.
- If the individual has multiple substance use diagnosis for the visit, report the individual in all SUD diagnosis stratifications for which they meet criteria.

The total is not a sum of the diagnosis cohorts. Count individuals in the total denominator rate if they had at least one alcohol, opioid or other drug abuse or dependence diagnosis during the measurement period. Report individual with multiple diagnoses during the Index Episode only once for the total rate for the denominator.

Step 3: Test for Negative Diagnosis History. Exclude individuals who had a claim/ encounter in any setting other than an ED visit (ED Value Set) or a medically managed withdrawal (i.e., detoxification) event (Detoxification Value Set) with a diagnosis of SUD (AOD Abuse and Dependence Value Set), SUD

medication treatment (AOD Medication Treatment Value Set) or an substance use disorder treatment medication dispensing event (Alcohol Use Disorder Treatment Medications List; Opioid Use Disorder Treatment Medications List) during the 60 days (2 months) before the IESD.

For an inpatient IESD, use the admission date to determine the 60-day Negative Diagnosis History period.

For ED or observation visits that result in an inpatient stay, use the earliest date of service (either the ED/observation date of service or the inpatient admission date) to determine the Negative Diagnosis History.

Step 4: Calculate continuous enrollment. Individuals must be continuously enrolled for 60 days (2 months) before the IESD through 47 days after the IESD (108 total days), with no gaps.

Exclusions:

- Exclude individuals who had a claim/encounter with a diagnosis of SUD (AOD Abuse and Dependence Value Set), SUD medication treatment (AOD Medication Treatment Value Set) or an substance use disorder treatment medication dispensing event (Alcohol Use Disorder Treatment Medications List; Opioid Use Disorder Treatment Medications List) during the 60 days (2 months) before the IESD.
- Exclude if used hospice during the measurement period (Hospice Encounter, Hospice Intervention Value Set).

Result:
The result is expressed as a percentage.

Improvement Direction:
Higher

Measure Deviations from Original Specifications:

- The measure steward age stratifies the results by 13-17 (N/A), 18+ and a Total. Only the age stratification that includes all ages (Total) will be used for QIP-NJ.
- Limited the age range of the measure to 18-64 years of age.
- In 2018 the measure steward began stratifying by SUD diagnosis cohort, alcohol abuse or dependence, opioid abuse or dependence, other drug abuse or dependence and total. Payment will not be impacted by performance across these stratifications.

Major Changes HEDIS MY 2020 and MY 2021:

- Clarified the Episode Date when detoxification occurs during an acute inpatient stay.
- Updated the step 3 instructions for ED and observation visits that result in an inpatient stay, to make them consistent with instructions in the Definitions section.
- Added value sets for opioid treatment services that are billed weekly or monthly to the denominator and numerators.
- Updated the continuous enrollment period.

Major Changes HEDIS MY 2022

- Replaced “alcohol and other drug (AOD)” references with “substance use disorder (SUD)”
- Revised Negative Diagnosis Criteria

Data Elements:

- Attributed to the BH population
- Index episode
- Admission date
- Follow up visit category
- Follow up visit date

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances:

- http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures.aspx
- http://www.qualityforum.org/QPS/0004

<table>
<tr><th colspan="5">Measure Collection Description</th></tr>
<tr><td colspan="2">Setting of Care:
Multi-setting</td><td colspan="3">Reporting Period:
Annual</td></tr>
<tr><td colspan="2">Measurement Period:
January 1, 2025 – December 31, 2025</td><td colspan="3">Baseline Period:
July 1, 2020 – December 31, 2020</td></tr>
<tr><td colspan="2">Payment Method:
P4P</td><td colspan="3">Measure Weight:
11.11%</td></tr>
<tr><td>Claim Type(s):

01, 03, 04, 14, 15, 18, 19</td><td>01 – Inpatient Hospital
02 – Long Term Care
03 – Outpatient Hospital
04 – Physician
05 – Chiropractor
06 – Home Health
07 – Transportation
08 – Vision</td><td>09 – Supplies, DME
10 – Podiatry
11 – Dental
12 – Pharmacy
13 – EPDST/Healthstart
14 – Institutional Crossover
15 – Professional Crossover</td><td colspan="2">16 – Lab
17 – Prosthetic and Orthotics
18 – Independent Clinic
19 – Psychologists
21 – Optometrists
22 – Mid Level Practitioner
23 – Hearing Aid</td></tr>
<tr><td colspan="2">Continuous Eligibility Period: Yes</td><td colspan="2">Risk Adjustment: No</td><td>Sampling: No</td></tr>
<tr><td colspan="5">Continuous Eligibility / Sampling Methodology: Individuals must be continuously enrolled without any gaps 60 days (2 months) prior to the IESD through 47 days after the IESD (108 total days). Following, November 14 is the last day in the calendar year that an individual is eligible for consideration into this measurement cohort. No sampling permitted.</td></tr>
</table>

Measure BH07: Preventive Care and Screening: Screening for Depression and Follow-Up Plan (PDS)

Measure Description:
Percentage of individuals 18 to 64 years of age screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool and if positive, a follow-up plan is documented on the date of the eligible encounter.

Data Source:	NQF #:
Chart/EHR	**Based on 0418**
Measure Steward:	Measure Steward Version:
CMS	**September 21, 2020**

Statewide Benchmark:
80%

Measure Calculation Description

Numerator:
Individuals who received a hospital outpatient or ED visit screen for depression (Table BH07_01: Codes to Document Depression Screen) on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized tool (as indicated by Logical Observation Identifiers Names and Codes (LOINC), if available, Table BH07_03, and tool score, or medical notes that clearly reflect the tool name and tool score that may be entered into the Standard Reporting Template) and, if positive, a follow-up plan is documented on the date of the eligible encounter, at least once during the measurement period.[8] If an individual has multiple screenings during the measurement year, a follow up must be documented following a positive screen on at least one of those encounters to be considered numerator compliant.

Any one of the following meets the criteria for an encounter:

- Revenue or CPT code (Table BH07_00: ED and Outpatient Hospital Revenue & CPT/HCPCS Value Set *)

Approved depression screening tools:
1A. Beck Depression Inventory (BDI)
1B. Beck Depression Inventory (BDI-II)
2. Clinically Useful Depression Outcome Scale (CUDOS
3. Depression Scale (DEPS)
4. Hamilton Rating Scale for Depression (HAM-D)
5. Major Depression Inventory (MDI)
6. Patient Health Questionnaire (PHQ-2)

[8] Individuals seen multiple times during the measurement period for an eligible encounter need not be screened more than once, unless clinically indicated.

7. Patient Health Questionnaire (PHQ-9*)
8. PROMIS Depression Total Score (T Score)
9. Zung Self-Rating Depression Scale
10. Other
11. Columbia Suicide Severity Screen (C-SSRS)
12. Patient Safety Screener (PSS-3) with follow-up of the ED-SAFE Secondary Screener (ESS-6)
13. National Institute of Mental Health (NIMH) - Suicide Risk Screening Tool (SSRS)
14. Edinburgh Postnatal Depression Screen (EPDS) for use with individuals who are ALSO attributed to the Maternal Health Population only
15. Patient Health Questionnaire (PHQ-4)

*The PHQ-2 should be used as a "first-step" approach; if the individual screens positive, they should be further evaluated with the PHQ-9.

Follow-Up Plan - Documented follow-up for a positive depression screening must include one or more of the following:

1. Referral to practitioner who is qualified to diagnose and treat depression
2. Pharmacological interventions
3. Other interventions, evaluations, or follow-up for the diagnosis or treatment of depression

Denominator:
All individuals 18 through 64 years of age at the beginning of the measurement period with at least one eligible outpatient or ED encounter (BH07_00) during the measurement period.

Exclusions:

- An individual is not eligible if one or more of the following diagnoses (Table BH07_02a) are documented within the current measurement period prior to the encounter date or in the 12 months prior to the measurement period, or
- Individual is in hospice (Table BH07_02b), or
- Individuals who are receiving Adult Mental Health Rehabilitation (AMHR) within the same calendar month or calendar month subsequent to the index admission (Table BH07_02c).

Exceptions[9]*:*
Individuals with a documented reason for not screening for depression:

- Individual refuses to participate (G8433, Screening for depression not completed, documented reason); examples may include:

[9] Denominator exceptions are conditions that remove a patient from the denominator only if the numerator criteria are not met (depression screening not completed, reason documented, e.g., medical reason for not performing a screening). Patients meeting the denominator exception criteria should still be reported. They allow for the adjustment of the final calculated score for hospitals exhibiting higher risk populations and are only used in proportional measures. Clinical codes representing what constitute an exception will be evaluated following submission of Baseline data and will be made available for MY1.

- Individual is in an emergent situation where time is of the essence and to delay treatment would jeopardize the individual's health status,
- The individual's functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools. For example: certain court appointed cases or cases of delirium.

Result:
Percentage

Improvement Direction:
Higher

Measure Deviations from Original Specifications:

- Setting has been expanded to both the ED and hospital outpatient setting
- Age is modified from 12 years and older to 18 years and older
- The list of CPT codes and HCPCS codes from BH07_00 has been removed
- The exclusions table (BH07_02) has been merged from three tables into one table
- A table of LOINC codes for screening tools (BH07_03) has been added to capture the screening tool; If LOINC is not captured in the EHR, the Standard Reporting Template has lookup options for the tool name
- Continuous eligibility requirements have been removed for this measure

Measure Updates for MY2:

- Removed suicide risk assessment and additional evaluation or assessment for depression as appropriate follow-up options to meet the numerator

Data Elements

- Attributed to the BH population
- Screening (index) date
- Encounter date
- Screening tool used
- Screening tool result
- Follow up plan documented
- Exclusionary diagnosis or other reason (if applicable)

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances:

- https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/ffy-2020-hh-core-set-manual.pd_2.pdf

- http://www.qualityforum.org/QPS/0418

Measure Collection Description		
Setting of Care: **ED or Outpatient**		Reporting Period: **Annual**
Measurement Period: **January 1, 2025 – December 31, 2025**		Baseline Period: **July 1, 2020 –December 31, 2020**
Payment Method: **P4P**		Measure Weight: **11.11%**
Continuous Eligibility Period: No	Risk Adjustment: **No**	Sampling: **Yes**
Continuous Eligibility / Sampling Methodology: **Sampling is permitted.**		

Data File Layout and Submission Requirements:

1. All data must be submitted for performance eligible individuals, in accordance with the sampling methodology
2. Enter all relevant data, including multiple screening events, per eligible individual
3. Any individuals who have become ineligible (e.g., no longer enrolled in MMC) should be removed from all results
4. Any additional information may be added to the submission comments in the "Standard Reporting Template"
5. Please refer to the "Standard Reporting Template" for more detail on submission requirements.

Measure BH08: Substance Use Screening and Intervention Composite

Measure Description: Percentage of individuals 18 to 64 years of age who received a substance use screening at least once within the last 12 months AND who received an intervention within the measurement period for all positive screening results.	
Data Source: **Chart/EHR**	NQF #: **Based on 2597**
Measure Steward: **ASAM**	Measure Steward Version: **March 06, 2015**
Statewide Target: **80%**	

Measure Calculation Description

Numerator:
Individuals 18 to 64 years of age who received the following substance use screenings (a valid HCPCS, CPT, UBREV or LOINC code from Table BH08_00) at least once within the last 12 months in the ED or outpatient setting AND who received at least one intervention during the measurement period for all positive screening results (a valid CPT, Revenue, HCPCS, or LOINC code from BH08_00: Health Visits & Screening Tools & SBIRT *):

Tobacco use component
Individuals who were screened for tobacco use at least once within the last 12 months AND who received tobacco cessation intervention during the measurement period if identified as a tobacco user

Unhealthy alcohol use component
Individuals who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 12 months AND who received brief counseling during the measurement period if identified as an unhealthy alcohol user

Drug use component (nonmedical prescription drug use and illicit drug use)
Individuals who were screened for nonmedical prescription drug use and illicit drug use at least once within the last 12 months using a systematic screening method AND who received brief counseling during the measurement period if identified as a nonmedical prescription drug user or illicit drug user

Acceptable screening tools are listed below by individual component and inclusive of the three components (if applicable):

Tobacco use component:

- Fagerstrom Test for Nicotine Dependence (FND)

Unhealthy alcohol use component:

- CAGE Questionnaire for Detecting Alcoholism
- The Alcohol Use Disorders Identification Test (AUDIT)
- The Alcohol Use Disorders Identification Test-Concise (AUDIT-C)

Drug use component:

- CAGE-AID Substance Abuse Screening Tool
- DAST-10 Prescription and Illicit Drug Use Screening

Inclusive (tobacco use, unhealthy alcohol use and drug use):

- NIDA Quick Screen
- NIDA Drug Use Screening Tool (NMASSIST)
- Tobacco, Alcohol, Prescription medication, and other Substance use (TAPS-1)
- NJ Perinatal Risk Assessment (PRA) – for obstetric patients only

Note: The inclusive screening tool encompasses all three components. If the individual screens positively on the NIDA Quick Screen, the NMASSIST should be administered as a follow-up tool.

Some hospital-specific tools have also been approved for this measure.

Denominator:
All individuals 18 through 64 years of age at the beginning of the measurement period with at least one eligible outpatient or ED encounter (BH08_00) during the measurement period.

Exclusions:

- Documentation of medical reason(s) for not screening (Table BH08_01: Medical Reasons for Not Screening)
- Use of opioids for chronic pain management (Medical notation that a pain contract agreement exists in the patient record; further detail may be accessed at: https://njafp.org/new-prescribing-law/)
- Limited life expectancy or hospice (Table BH08_01: Codes for Hospice)
- ED visits that result in an observation stay (Table BH08_01: Additional CPT Codes (Observation)

Result:
Percentage

Improvement Direction:
Higher

Measure Deviations from Original Specifications:

- Setting has been expanded to both the ED and hospital outpatient setting
- Visits determined by multiple codes, including revenue and HCPCS codes – addition of value set "Mental Health Follow-Up Revenue Value Set"
- Time period for tool administration has been modified from 24 months to 12 months
- The recommended list of valid screening tools has been augmented
- Continuous eligibility requirements have been removed for this measure

Data Elements:

- Attributed to the BH population
- Screening date
- Screening tool(s) used
- Screening tool(s) result
- Follow up plan
- Exclusionary diagnosis or other reason (if applicable)

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances:

- http://www.qualityforum.org/QPS/2597

Measure Collection Description		
Setting of Care: **Outpatient and ED**		Reporting Period: **Annual**
Measurement Period: **January 1, 2025 – December 31, 2025**		Baseline Period: **July 1, 2020 –December 31, 2020**
Payment Method: **P4P**		Measure Weight: **11.11%**
Continuous Eligibility Period: **No**	Risk Adjustment: **No**	Sampling: **Yes**

Continuous Eligibility / Sampling Methodology: **Sampling is permitted.**

Data File Layout and Submission Requirements:

1. All data must be submitted for performance eligible individuals only, in accordance with sampling guidelines.
2. Hospitals should submit as much relevant data as possible, however, to reduce administrative burden, hospitals can choose to report only the ED visit that resulted in the administration of the tool for the 3 components when there are multiple ED visits logged.
3. Any individuals who have become ineligible (e.g., no longer enrolled in MMC) should be removed from all results
4. Any additional information may be added to the submission comments in the "Standard Reporting Template"

5. Please refer to the “Standard Reporting Template” for more detail on submission requirements.

Measure BH09: Timely Transmission of Transition Record (Behavioral Health)

Measure Description:
Percentage of individuals 18 to 64 years of age discharged from an inpatient facility to home or other specified site of care for whom a transition record was transmitted to the facility, primary care physician, or other health care professional designated for follow-up care within 24 hours of discharge.

Data Source:	NQF #:
Chart/EHR	**Based on 0648**
Measure Steward:	Measure Steward Version:
AMA-PCPI	**June 28, 2017**

Statewide Benchmark:
80%

Measure Calculation Description

Numerator:
Individuals with a principal behavioral health or AOD diagnosis (Table BH09_00) for whom a transition record was transmitted to the facility/physician/other health care professional designated for follow-up care within 24 hours of discharge.

Transition record - A core, standardized set of data elements related to patient's diagnosis, treatment, and care plan that is discussed with and provided to patient in printed or electronic format at each transition of care and transmitted to the facility/physician/other health care professional providing follow-up care. Electronic format may be provided only if acceptable to patient.

Transmitted – The transition record may be transmitted to the facility or physician or other health care professional designated for follow-up care via fax, secure e-mail, or mutual access to an electronic health record (EHR).

Primary physician or other health care professional designated for follow-up care - May be a designated primary care physician (PCP), medical specialist, or other physician or health care professional.

Denominator:
Of the attributed behavioral health population, individuals 18 to 64 years of age discharged from an inpatient facility (Table BH09M06_01a) to home/self-care or any other designated site of care (Table BH09M06_01b) with a principal mental health or AOD diagnosis (Table BH09_00).

Exclusions:

- Individuals who expired, left against medical advice, or discontinued care (BH09M06_02).

Result:
The result is expressed as a percentage.

Improvement Direction:
Higher

Measure Deviations from Original Specifications:

- Added principal behavioral health diagnosis requirement.

Data Elements:

- Attributed to the BH population
- Diagnosis of Care (Working Diagnosis) (Table BH09_00)
- Bill Type Code
- Patient Discharge Status Code
- Discharge Date
- Patient Discharge Summary Transmission Date

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances:

- http://www.qualityforum.org/QPS/0648

Measure Collection Description		
Setting of Care: **Inpatient**	Reporting Period: **Annual**	
Measurement Period: **January 1, 2025 – December 31,2025**	Baseline Period: **July 1, 2020 –December 31, 2020**	
Payment Method: **P4P**	Measure Weight: **11.11%**	
Continuous Eligibility Period: **No**	Risk Adjustment: **No**	Sampling: **Yes**
Continuous Eligibility / Sampling Methodology: **Sampling is permitted.**		

Data File Layout and Submission Requirements:

1. All data must be submitted for performance eligible individuals only, in accordance with sampling guidelines
2. Enter all relevant data, per eligible individual
3. Any individuals who have become ineligible (e.g., no longer enrolled in MMC) should be removed from all results

4. Any additional information may be added to the submission comments in the “Standard Reporting Template”
5. Please refer to the “Standard Reporting Template” for more detail on submission requirements

Measure BH10: 3-Item Care Transitions Measure (CTM-3)

Measure Description: The CTM-3 is a hospital level measure of performance that reports the average patient reported quality of preparation for self-care response among individuals 18 to 64 years of age from ACHs within the past 30 days.	
Data Source: **Instrument-Based**	NQF #: **Based on 0228**
Measure Steward: **University of Colorado Denver Anschutz Medical Campus**	Measure Steward Version: **December 16, 2019**
Statewide Benchmark: **N/A**	

Measure Calculation Description

Numerator:
The numerator is the hospital level sum of the CTM-3 scores for all eligible sampled individuals. Hospitals may submit results from Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) (Please note: effective calendar year 2025: CMS removed the following questions from the HCAHPS – if your facility has added them in as custom questions to the HCAHPS you may use those) and/or Experience of Care and Health Outcomes (ECHO) surveys in lieu of administering an independent survey.

The items and response options are as follows:

1. The hospital staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left the hospital.
   ☐ Strongly Disagree
   ☐ Disagree
   ☐ Agree
   ☐ Strongly Agree
   ☐ Don't Know/Don't Remember/Not Applicable

2. When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.
   ☐ Strongly Disagree
   ☐ Disagree
   ☐ Agree
   ☐ Strongly Agree
   ☐ Don't Know/Don't Remember/Not Applicable

3. When I left the hospital, I clearly understood the purpose for taking each of my medications.
   ☐ Strongly Disagree
   ☐ Disagree
   ☐ Agree
   ☐ Strongly Agree
   ☐ I was not given any medication when I left the hospital

There are 5 response options for Q1 and Q2: Strongly Disagree = 1, Disagree = 2, Agree = 3, Strongly Agree = 4, Don't know/Don't remember/Not applicable = 0

There are 6 response options for Q3: Strongly Disagree = 1, Disagree = 2, Agree = 3, Strongly Agree = 4, I was not given any medication when I left the hospital = 5 (for HCAHPS CTM-3 only), Don't Know/Don't Remember/Not Applicable = 0 (Standalone CTM-3 only)

The range of total raw score per individual is 0 to 13.

ECHO responses for questions 12, 18 and 22, respectively:

1. In the last 12 months, how often did the people you went to for counseling or treatment explain things in a way you could understand?
   ☐ Never
   ☐ Sometimes
   ☐ Usually
   ☐ Always

2. In the last 12 months, how often were you involved as much as you wanted in your counseling or treatment?
   ☐ Never
   ☐ Sometimes
   ☐ Usually
   ☐ Always

3. In the last 12 months, were you given as much information as you wanted about what you could do to manage your condition?
   ☐ Yes
   ☐ No

There are four response options for questions 12 and 18. Never = 1, Sometimes = 2, Usually = 3 and Always = 4.

There are two response options for question 22. Yes = 1 and No = 0.

Therefore the range of score will be 2-9, with a score of 9 being the most positive response.

Denominator:
Of the attributed behavioral health population, the number of eligible sampled adults discharged from an ACH.

Exclusions:

- Individuals under age 18,
- Individuals who died in the hospital, and
- Individuals who did not stay at least one night in the hospital,
- Individuals over age 64.

Please note: Reporting on this measure is optional for MY5

Result:
The result is expressed as an average score.

Improvement Direction:
Higher

Measure Deviations from Original Specifications:

- Permit the submission of data from HCAHPS and ECHO surveys in addition to independent survey design.

Data Elements:

- Attributed to the BH population
- Survey date
- Survey tool result
- Follow up plan
- Exclusionary diagnosis or other reason (if applicable)

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances: http://www.qualityforum.org/QPS/0228

Measure Collection Description

Setting of Care: **Inpatient**		Reporting Period: **Annual**
Measurement Period: **January 1, 2025 – December 31, 2025**		Baseline Period: **July 1, 2020 – December 31, 2020**
Payment Method: **NA**		Measure Weight: **NA**
Continuous Eligibility Period: NA	Risk Adjustment: **No**	Sampling: **Yes**

Continuous Eligibility / Sampling Methodology: **Sampling is permitted.**

Survey Administration

- Survey should be administered between 48 hours and 30 days post discharge, regardless of mode of administration.
- No proxies are permitted to respond on behalf of patients. Someone other than the person who received care is permitted to read the questions to the respondent and/or record the responses.
- May be administered as a stand-alone instrument or combined with other hospital-specific questions.
- Data collection shall be closed out no later than 4 weeks following start of data collection for that respondent.
- Mode of delivery:
    1. Mail-only – includes CTM-3 only or combined with other hospital-specific questions. With cover letter that may be tailored but must include language indicating the purpose of the survey, explanation that participation is voluntary, and statement that the individual's health benefits will not be affected by participation.
    2. Telephone-only – Standardized script should be used, interviewers administering the surveys must be trained, and must attempt to contact respondent at least five times unless respondent refuses to complete the survey.
    3. Mixed mode of mail and telephone – Specifications for mail-only and telephone-only apply, except second mailing is not required and only non-respondents shall be contacted by telephone at least five times as per telephone only mode.
    4. Electronic/Mixed mode of email, text, and phone call – Submission of data is allowed if secure transmission protocols exist and if data may be appropriately mapped into respective answers.

    Note: any inquiries about the mode of delivery for the survey should be directed to QIP-NJ@pcgus.com.

Where CTM-3 questions or survey guidance differ from CMS guidance for HCAHPS (i.e. timeframe for closing out data collection), hospitals submitting HCAHPS results should defer to CMS guidance.

Data Submission Requirements

1. All data must be submitted for performance eligible individuals only, in accordance with sampling guidance
2. Enter all relevant data, including multiple survey events, per eligible individual
3. Any individuals who have become ineligible (e.g., no longer enrolled in MMC) should be removed from all results
4. Any additional information may be added to the submission comments in the "Standard Reporting Template"
5. Please refer to the "Standard Reporting Template" for more detail on submission requirements

Measure BH11: Use of a Standardized Screening Tool for Social Determinants of Health

Measure Description:
For the BH population served, the percent of individuals 18 to 64 years of age who have received a screening using a validated tool including SDOH domains identified by the State.

Data Source:	NQF #:
Instrument-Based	**N/A**
Measure Steward:	Measure Steward Version:
NJ DOH	**July 1, 2021**

Statewide Benchmark:
N/A

Measure Calculation Description

Numerator:
Of the attributed population with Behavioral Health needs attributed to the facility, those that received a screening in the outpatient or ED setting using a validated tool including SDOH domains identified by the State of New Jersey.

Domains required by the State (4):

1. Housing
2. Food Security
3. Transportation
4. Social Supports

Validated screening tools:

1. American Academy of Family Physicians (AAFP): Social Determinants of Health
2. PRAPARE: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences
3. NJ Perinatal Risk Assessment (PRA) only for an individual that is an obstetric patient

Some hospital-specific tools have also been approved for this measure.

Denominator:
The population with Behavioral Health needs attributed to the facility.

Result:
The result is expressed as a percentage.

Improvement Direction:

Data Elements:

- Attributed to the BH population
- Survey date
- Survey tool
- Survey tool result
- Exclusionary diagnosis or other reason (if applicable)

Measure Collection Description		
Setting of Care: **Multi-setting (OP or ED)**		Reporting Period: **Annual**
Measurement Period: **January 1, 2025 – December 31, 2025**		Baseline Period: **July 1, 2020 – December 31, 2020**
Payment Method: **NA**		Measure Weight: **NA**
Continuous Eligibility Period: NA	Risk Adjustment: **No**	Sampling: **Yes**
Continuous Eligibility / Sampling Methodology: **Sampling is permitted.**		

Data Submission Requirements:

1. All data must be submitted for performance eligible individuals only, in accordance with sampling guidance
2. Enter all relevant data, including multiple survey events, per eligible individual
3. Any individuals who have become ineligible (e.g., no longer enrolled in MMC) should be removed from all results
4. Any additional information may be added to the submission comments in the "Standard Reporting Template"
5. Please refer to the "Standard Reporting Template" for more detail on submission requirements

Measure BH12: Reducing Disparities and Improving Patient Experience Through Targeted Training

Measure Description:
The percentage of hospital staff who have received at least one implicit bias training during the measurement year and the percentage of hospital staff who have received at least one Social Determinants of Health (SDOH) training during the measurement year.

Data Source:	NQF #:
Administrative	**N/A**
Measure Steward:	Measure Steward Version:
NJ DOH	**N/A**

Statewide Target:
N/A

Measure Calculation Description

Numerator:
Number of hospital staff that have received at least one training related to implicit bias **AND** at least one training related to SDOH during the MY.

SDOH training must meet the following criteria[10,11 12]:

- Describing and addressing the five (5) key areas of SDOH -- education, economic stability, neighborhood and built environment, health and health care, and social and community context – and understanding how each can impact health outcomes;
- Exploring the relationship between social determinants of health and health disparities, including specific examples; and
- An overview of the SDOH tools currently in place at the hospital including, how to access the tools, who is required to complete the tools, and what process is in place at the hospital if a patient screens positive.

As part of a hospital's **overall SDOH program**, DOH recommends the following considerations:

- Identifying social determinants of health during clinical encounters and ensuring community health assessments (CHA) include SDOH measures and engaging communities and multi-sectoral partners.
- Identifying how hospitals and their partners can consider how conditions in the places where people live, learn, work, and play affect a wide range of health risks and outcomes, which should include a system for monitoring health outcomes, collecting data, developing policies, creating an informed and competent workforce, providing appropriate linkages to care, and a method for evaluating effectiveness of processes and if/as needed, implementing quality improvement strategies.

[10] "The Social Determinants of Health: The Root of the Health Center Program." *The Social Determinants of Health Academy*. 23 Jan. 2020. Foundational Trainings — The SDOH Academy
[11] "CDC Programs Addressing Social Determinants of Health." *Centers for Disease Control and Prevention*. 14 Oct. 2021. CDC Programs Addressing SDOH | Social Determinants of Health | CDC
[12] "Ten Essential Public Health Services and How They Can Include Addressing Social Determinants of Health Inequities." *Centers for Disease Control and Prevention*. Ten Essential Services SDOH F (cdc.gov)

- Implementing innovative solutions, evidence-based tools, and actions to address SDOH considerations and the resulting health inequities, which be incorporated throughout all aspects of health care services and various delivery modalities.
- Creating broader awareness of how key health care practices can better incorporate consideration of SDOH, inclusive of incorporating SDOH measures as basis for addressing community health problems and inequities and finding ways to mobilize community partnerships.
- Sharing information and best practices as to how health care practitioners can transform and strengthen their capacity and impact to advance health equity.

Implicit Bias training must meet the following criteria[13]:

- identifying environmental, personal, interpersonal, institutional, and cultural barriers to inclusion;
- information on the effects of historical and contemporary exclusion and oppression of minority communities;
- information about cultural identity across racial, ethnic, and other marginalized groups;
- information about communicating more effectively across racial, ethnic, religious, and gender identities;
- a discussion on power dynamics and organizational decision-making and their effects on explicit and implicit bias
- corrective measures to decrease explicit and implicit bias at the interpersonal and institutional levels.

Denominator:

Hospital-employed (including per diem) healthcare professionals and patient-facing support staff that interact with BH patients. At their discretion, hospitals may include hospital-employed, community-based staff in the denominator, however, if community-based staff are included, they must be included in the denominator every year. See SRT Frequently Asked Questions for detailed information about whom to include/exclude.

Exclusions: Employees hired between December 1 – December 31 of the MY.

Result:

The result is expressed as a percentage.

Improvement Direction:

Higher

Data Elements:

- Hospital Staff first name
- Hospital Staff last name
- Implicit Bias Training Course Name
- Social Determinants of Health (SDOH) Training Course Name
- Date of Course(s)
- EmployeeID or other unique identifier for hospital staff

[13] Senate Bill 703/Assembly Bill 1079, Approved P.L.2021, c.79 (state.nj.us)

Measure Collection Description		
Setting of Care: **N/A**	Reporting Period: **Annual**	
Measurement Period: **January 1, 2025 – December 31, 2025**	Baseline Period: **January 1, 2022 –December 31, 2022**	
Payment Method: **NA**	Measure Weight: **NA**	
Continuous Eligibility Period: **N/A**	Risk Adjustment: **No**	Sampling: **N/A**

Continuous Eligibility / Sampling Methodology: **Does not apply / no sampling permitted.**

Data Submission Requirements:

1. Enter all relevant data, including multiple training events, per eligible individual
2. Any additional information, including which tool was used, should be added to the submission comments in the "Standard Reporting Template"
3. Please refer to the "Standard Reporting Template" for more detail on submission requirements

III. Measurement Specifications: Maternal Health Measure Set

A. Maternal Health Measures Grid

Measure #	Measure Name and NQF #	Measure Steward	Data Source	State Baseline	VBP Reporting Years	Measure Weight
M001	Severe Maternal Morbidity (SMM)	CDC	MMIS	"Year 0" (7/1/2020-12/31/2020) claims data	Pay-for-performance in all years	14.29%
M002	PC-02 Cesarean Birth - NQF #0471	Joint Commission	Chart/EHR	"Year 0" (7/1/2020-12/31/2020) hospital reported data	Pay-for-performance in all years	14.29%
M003	Postpartum Depression Screening – NQF #1401	NCQA	Chart/EHR	"Year 0" (7/1/2020-12/31/2020) hospital reported data	Pay-for-performance in all years	14.29%
M004	Postpartum Care - NQF #1517	NCQA	MMIS	"Year 0" (7/1/2020-12/31/2020) claims data	Pay-for-performance in all years	14.29%
M005	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment in Pregnant Women -NQF #0004	NCQA	MMIS	"Year 0" (7/1/2020-12/31/2020) claims data	Pay-for-performance in all years	14.29%
M006	Timely Transmission of the Transition Record- NQF #0648	AMA-PCPI	Chart/EHR	“Year 0” (7/1/2020-12/31/2020) Hospital reported data	Pay-for-performance in all years	14.29%

M007	Treatment of Severe Hypertension	Alliance for Innovation on Maternal Health (AIM)	Chart/EHR	Y1: 7/1/2021-12/31/2021 Hospital reported data	Pay-for-performance in all years	14.29%
M008	3-Item Care Transitions Measure (CTM-3)	University of Colorado Denver Anschutz Medical Campus	Instrument	"Year 0" (7/1/2020-12/31/2020) Hospital reported data	Reporting only (Optional in MY5)	0%
M009	Use of a Standardized Screening Tool for Social Determinants of Health	NJ DOH	Instrument	"Year 0" (7/1/2020-12/31/2020) Hospital reported data	Reporting only	0%
M010	Reducing Disparities and Improving Patient Experience Through Targeted Training	NJ DOH	Training Records	"Year 0" (1/1/2022-12/31/2022) Hospital reported data	Reporting only	0%

Figure 11. Maternal Health Measures Grid

Measure M001: Severe Maternal Morbidity (SMM)

Measure Description:
For the Maternal Health population served aged 12 to 55 years old, the percentage of births resulting in Severe Maternal Morbidities as defined by the CDC.

Data Source:	NQF #:
MMIS	**N/A**
Measure Steward:	Measure Steward Version:
CDC	**December 26, 2019**

Statewide Benchmark:
8.16/1,000 delivery hospitalizations excluding transfusions

Measure Calculation Description

Numerator:

- The number of birthing individuals with severe maternal morbidities aged 12 to 55 years of age identified in the diagnosis and procedure code sets identified by CDC (Table M01_00). Individuals with a diagnosis of SARS-COV-2 at the time of delivery (Table M01_02) should be excluded from the numerator only. Individuals with a length of stay shorter than the 90th percentile for the MY (note: this will be calculated based upon the LOS data analyzed during the respective MY) will also be excluded.

To identify delivery hospitalizations with SMM, CDC uses administrative hospital discharge data and International Classification of Diseases (ICD) diagnosis and procedure codes. The updated list of 21 indicators and corresponding ICD codes used to identify delivery hospitalizations with SMM for ICD-10 may be used to track SMM when using administrative hospital discharge data.

For all pregnancy related codes O00-O9A:
1. Only identify events that occur during the birth admission
2. Are only applicable to maternity patients aged 12 – 55 years inclusive
3. Due to rare prevalence, the following indicators may be combined for reporting purposes:
    - Acute myocardial infarction and aneurysm,
    - Cardiac arrest/ventricular fibrillation and conversion of cardiac rhythm, and
    - Temporary tracheostomy and ventilation.

Denominator:
All individuals with a delivery (Table M1M4M5Denom_APR_DRG_Detail) at the ACH during the MY.

Exclusions:

- Pregnancy complications and abnormal products of conception (Table M01_02).

Result:
The result is expressed as a rate.

Improvement Direction:
Lower

Measure Deviations from Original Specifications:

- Excluded lengths of stay shorter than the 90th percentile for the measurement year to align with NJ Maternal Health Hospital Report Card specification.
- Excluded individuals from the numerator with a diagnosis of SARS-COV-2 at the time of delivery.

Data Elements:

- Attributed to the maternal health population
- SMM Indicator
- Birth Admission Code / Discharge Diagnosis

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances:

- https://www.cdc.gov/reproductivehealth/maternalinfanthealth/smm/severe-morbidity-ICD.htm

<table>
<tr><th colspan="5">Measure Collection Description</th></tr>
<tr><td colspan="2">Setting of Care:
Site of Birth Admission</td><td colspan="3">Reporting Period:
Annual</td></tr>
<tr><td colspan="2">Measurement Period:
January 1, 2025 – December 31, 2025</td><td colspan="3">Baseline Period:
July 1, 2020 –December 31, 2020</td></tr>
<tr><td colspan="2">Payment Method:
P4P</td><td colspan="3">Measure Weight:
14.29%</td></tr>
<tr><td>Claim Type(s):

01</td><td>01 – Inpatient Hospital
02 – Long Term Care
03 – Outpatient Hospital
04 – Physician
05 – Chiropractor
06 – Home Health
07 – Transportation
08 – Vision</td><td>09 – Supplies, DME
10 – Podiatry
11 – Dental
12 – Pharmacy
13 – EPDST/Healthstart
14 – Institutional Crossover
15 – Professional Crossover</td><td colspan="2">16 – Lab
17 – Prosthetic and Orthotics
18 – Independent Clinic
19 – Psychologists
21 – Optometrists
22 – Mid Level Practitioner
23 – Hearing Aid</td></tr>
<tr><td colspan="2">Continuous Eligibility Period: No</td><td colspan="2">Risk Adjustment: No</td><td>Sampling: No</td></tr>
<tr><td colspan="5">Continuous Eligibility / Sampling Methodology: No sampling permitted.</td></tr>
<tr><td colspan="5"></td></tr>
</table>

Measure M002: PC-02 Cesarean Birth

Measure Description:
This measure assesses the rate of nulliparous birthing individuals 8 to 64 years of age with a term, singleton baby in a vertex position delivered by Cesarean birth.

Data Source:	NQF #:
Chart/EHR	**Based on 0471**
Measure Steward:	Measure Steward Version:
The Joint Commission	**November 20, 2020**

Statewide Benchmark:
23.6/100 deliveries

Measure Calculation Description

Numerator

Individuals having an ICD-10-PCS Procedure Code for a Cesarean delivery (Table M02_03).

Denominator

Of the attributed population, nulliparous individuals who deliver:

- A live term singleton newborn (Table M02_00),
- In vertex presentation (Table M02_01),
- With >= 37 (Table M02_02) completed.

Note: Nulliparous and vertex data elements have been added to the Standard Reporting Template; therefore, no clinical codes need to be explicitly added.

Exclusions:

- An ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes for Multiple Gestations and Other Presentations (Table M02_04), including **active** cases of genital herpes
- Gestational age < 37 or unable to determine (UTD) (Table M02_04)
- Less than 8 years or are greater than or equal to 65 years of age
- A length of stay > 120 days
- Active enrollment in any clinical trial

Result:
The result is expressed as a rate.

Improvement Direction:
Lower

Measure Deviations from Original Specifications:

- None

Data Elements:

- Attributed to the maternal health population
- Cesarean delivery (index date)
- Discharge date
- Gestational age
- Delivery in vertex presentation
- Previous live births

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances:

- http://www.qualityforum.org/QPS/0471
- https://manual.jointcommission.org/releases/TJC2019A/MIF0167.html

<table>
<tr><th colspan="4">Measure Collection Description</th></tr>
<tr><td colspan="2">Setting of Care:
Site of Birth Admission</td><td colspan="2">Reporting Period:
Annual</td></tr>
<tr><td colspan="2">Measurement Period:
January 1, 2025 – December 31, 2025</td><td colspan="2">Baseline Period:
July 1, 2020 –December 31, 2020</td></tr>
<tr><td colspan="2">Payment Method:
P4P</td><td colspan="2">Measure Weight:
14.29%</td></tr>
<tr><td>Claim Type(s):

01</td><td>01 – Inpatient Hospital
02 – Long Term Care
03 – Outpatient Hospital
04 – Physician
05 – Chiropractor
06 – Home Health
07 – Transportation
08 – Vision</td><td>09 – Supplies, DME
10 – Podiatry
11 – Dental
12 – Pharmacy
13 – EPDST/Healthstart
14 – Institutional Crossover
15 – Professional Crossover</td><td>16 – Lab
17 – Prosthetic and Orthotics
18 – Independent Clinic
19 – Psychologists
21 – Optometrists
22 – Mid Level Practitioner
23 – Hearing Aid</td></tr>
<tr><td colspan="2">Continuous Eligibility Period: No</td><td>Risk Adjustment: No</td><td>Sampling: Yes</td></tr>
<tr><td colspan="4">Continuous Eligibility / Sampling Methodology: Sampling is permitted.</td></tr>
</table>

Data Submission Guidelines:

1. All data must be submitted for performance eligible individuals only, in accordance with the sampling methodology
2. Enter all relevant data, including multiple events, per eligible individual
3. Any individuals who have become ineligible (e.g., no longer enrolled in MMC) should be removed from all results
4. Any additional information may be added to the submission comments in the "Standard Reporting Template"
5. Please refer to the "Standard Reporting Template" for more detail on submission requirements

Measure M003: Maternal Depression Screening (PDS-E)

Measure Description: The percentage of birthing individuals who had a screening for maternal depression at least once between delivery (index date) and prior to discharge.	
Data Source: **Chart / EHR**	NQF #: **Based on 1401**
Measure Steward: **NCQA**	Measure Steward Version: **HEDIS® MY 2020 & MY 2021 (ECDS)** **July 31, 2014**
Statewide Benchmark: **90%**	

Measure Calculation Description

Numerator:
Birthing individuals who had a documented result of a maternal depression screening (Table M03_01) using an age-appropriate standardized instrument (as indicated by Logical Observation Identifiers Names and Codes (LOINC) if available, Table M03_03, and tool score, or medical notes that clearly reflect the tool name and tool score) at least once between delivery and prior to discharge by any licensed practitioner.

Approved depression screening tools:

1A. Beck Depression Inventory (BDI)
1B. Beck Depression Inventory (BDI-II)
2. Clinically Useful Depression Outcome Scale (CUDOS
3. Depression Scale (DEPS)
4. Hamilton Rating Scale for Depression (HAM-D)
5. Major Depression Inventory (MDI)
6. Patient Health Questionnaire (PHQ-2)
7. Patient Health Questionnaire (PHQ-9*)
8. PROMIS Depression Total Score (T Score)
9. Zung Self-Rating Depression Scale
10. Other
11. Edinburgh Postnatal Depression Scale (EPDS)
12. NIMH Suicide Risk Screening Tool (SSRS)

*The PHQ-2 should be used as a “first-step” approach; if the patient screens positive, she should be further evaluated with the PHQ-9

Denominator:
All live births of birthing individuals in the defined QIP-NJ Maternal Health Population who delivered (Table M03_Deliveries) at the hospital during the MY.

Exclusions:
Individuals that:

- Were transferred to another facility before or after delivery
- Expired prior to discharge (Table M03_02)
- Delivered in hospice or used hospice during the measurement period (Table M03_Hospice)

Result:
The result is expressed as a percentage.

Improvement Direction:
Higher

Measure Deviations from Original Specifications:

- Changed denominator from a count of children to a count of post-partum birthing individuals
- Modified from inpatient maternal screening at time of birth and prior to discharge; originally, from outpatient place of service that occurs 7 to 84 days of delivery or within child's first 6 months of life
- Modified to only include one rate to report "Depression Screening"; original has two rates that includes "Follow-Up on Positive Screen"
- Because of the time-sensitive targeted intervention irrespective of an existing behavioral health diagnosis, removed four value sets ("Depression Case Management Encounter", "Behavioral Health Encounter", "Depression or Other Behavioral Health Condition", and "Follow Up Visit"

Major Changes HEDIS MY 2020 and MY 2021:
N/A

Data Elements:

- Attributed to the maternal health population
- Delivery
- Depression screen with standardized validation tool

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances:

- http://www.qualityforum.org/QPS/1401

Measure Collection Description			
Setting of Care: **Inpatient**		Reporting Period: **Annual**	
Measurement Period: **January 1, 2025 – December 31, 2025**		Baseline Period: **July 1, 2020 –December 31, 2020**	
Payment Method: **P4P**		Measure Weight: **14.29%**	
Claim Type(s): **01**	**01** – Inpatient Hospital **02** – Long Term Care **03** – Outpatient Hospital **04** – Physician **05** – Chiropractor **06** – Home Health **07** – Transportation **08** – Vision	**09** – Supplies, DME **10** – Podiatry **11** – Dental **12** – Pharmacy **13** – EPDST/Healthstart **14** – Institutional Crossover **15** – Professional Crossover	**16** – Lab **17** – Prosthetic and Orthotics **18** – Independent Clinic **19** – Psychologists **21** – Optometrists **22** – Mid Level Practitioner **23** – Hearing Aid
Continuous Eligibility Period: **No**	Risk Adjustment: **No**	Sampling: **Yes**	

Continuous Eligibility / Sampling Methodology: **Sampling is permitted.**

Data Submission Requirements

1. All data must be submitted for performance eligible individuals only, in accordance with the sampling guidance.
2. Enter all relevant data, including multiple events, per eligible individual
3. Any individuals who have become ineligible (e.g., no longer enrolled in MMC) should be removed from all results
4. Any additional information may be added to the submission comments in the "Standard Reporting Template"
5. Please refer to the "Standard Reporting Template" for more detail on submission requirements

Measure M004: Postpartum Care (PPC)

Measure Description: The percentage of deliveries of live births on or before October 7 of the MY. For these birthing individuals, the percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.	
Data Source: **MMIS**	NQF #: **Based on 1517**
Measure Steward: **NCQA**	Measure Steward Version: **HEDIS® MY 2020 & MY 2021** **October 25, 2016**
Statewide Benchmark: **75%**	

Measure Calculation Description

Numerator:
Individuals who had a postpartum visit on or between 7 and 84 days after delivery. Any of the following meet criteria:

- A postpartum visit (M04_DetailOID > Postpartum Visits Value Set).
- Cervical cytology (M04_DetailOID > Cervical Cytology Lab Test Value Set; Cervical Cytology Result or Finding Value Set).
- A bundled service (M04_DetailOID > Postpartum Bundled Services Value Set) where the organization can identify the date when postpartum care was rendered (because bundled service codes are used on the date of delivery, not on the date of the postpartum visit, these codes may be used only if the claim form indicates when postpartum care was rendered).
- Services provided via telephone (M04_DetailOID > Telephone Visits Value Set), e-visits and virtual check-ins (M04_DetailOID > Online Assessments Value Set) may be used.

Denominator:
Individuals who delivered a live birth on or before October 7 of the MY. Include birthing individuals who delivered in any setting except hospice.

Note on Multiple births: Birthing individuals who had two separate deliveries (different dates of service) within the MY count twice. Individuals who had multiple live births during one pregnancy count once.

Follow the steps below to identify the eligible population:

Step 1: Identify deliveries.
Identify all birthing individuals with a delivery (M1M4M5Denom_APR_DRG_Detail) before October 7 of the MY.

> Note: The intent is to identify the date of delivery (the date of the "procedure"). If the date of delivery cannot be interpreted on the claim, use the date of service or, for inpatient claims, the date of discharge.

Step 2: Exclude non-live births (M04_DetailOID > Non-live Births Value Set).

Step 3: Identify continuous enrollment. Determine if enrollment was continuous 43 days prior to delivery through 60 days after delivery, with no gaps.

Exclusions:
Services:

- Provided in an acute inpatient setting (M04_DetailOID > Acute Inpatient Value Set; Acute Inpatient POS Value Set)
- Provided in hospice delivery setting (M04_DetailOID > Hospice Encounter or Hospice Intervention Value Set)
- Resulting in non-live births (M04_DetailOID > Non-live Births Value Set)

Result:
The result is expressed as a percentage.

Improvement Direction:
Higher

Measure Deviations from Original Specifications:

- Adjusted timeframes to align with the QIP-NJ MY.

Although PPC typically also includes a measure of prenatal care, this has been removed to focus on hospital related care.

Major Changes HEDIS MY 2020 and MY 2021:

- Revised the definition of last enrollment segment.
- Clarified that visits that occur prior to the enrollment start date (during the pregnancy) meet criteria.
- Added telephone visits (M04_DetailOID > Telephone Visits Value Set) e-visits and virtual check-ins (M04_DetailOID > Online Assessments Value Set)
  Continuous eligibility requirements have been removed for this measure

Data Elements:

- Attributed to the maternal health population
- Index date
- Follow up visit

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances:

- http://www.qualityforum.org/QPS/1517

Measure Collection Description

Setting of Care: **Outpatient**		Reporting Period: **Annual**	
Measurement Period: **January 1, 2025 – December 31, 2025**		Baseline Period: **July 1, 2020 – December 31, 2020**	
Payment Method: **P4P**		Measure Weight: **14.29%**	
Claim Type(s): **04, 14, 15, 19, 23**	**01** – Inpatient Hospital **02** – Long Term Care **03** – Outpatient Hospital **04** – Physician **05** – Chiropractor **06** – Home Health **07** – Transportation **08** – Vision	**09** – Supplies, DME **10** – Podiatry **11** – Dental **12** – Pharmacy **13** – EPDST/Healthstart **14** – Institutional Crossover **15** – Professional Crossover	**16** – Lab **17** – Prosthetic and Orthotics **18** – Independent Clinic **19** – Psychologists **21** – Optometrists **22** – Mid Level Practitioner **23** – Hearing Aid
Continuous Eligibility Period: **No**	Risk Adjustment: **No**	Sampling: **No**	

Continuous Eligibility / Sampling Methodology: **Sampling is permitted.**

Measure M005: Treatment of Substance Use Disorder (SUD) in Pregnant Women (Initiation of Alcohol and Other Drug Treatment) (IET – I)

Measure Description:
The percentage of pregnant birthing individuals aged 18 years old through 64 years old with a new episode of substance use disorder (SUD) who initiate treatment through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the diagnosis.

Data Source:	NQF #:
MMIS	**Based on 0004**
Measure Steward:	Measure Steward Version:
NCQA	**HEDIS® MY 2020 & MY 2021** **June 10, 2019**

Statewide Benchmark:
55%

Measure Calculation Description

Definitions:

Intake Period	January 1–November 14 of the MY. The Intake Period is used to capture new episodes of SUD.
Index Episode	The earliest eligible encounter during the Intake Period with a diagnosis of SUD. *For ED or observation visits that result in an inpatient stay*, the inpatient discharge is the index episode.
Date of service for services billed weekly or monthly	For an opioid treatment service that bills monthly or weekly, the claim must contain a verifiable date of service (OUD Weekly Non-Drug Service Value Set; OUD Monthly Office Based Treatment Value Set; OUD Weekly Drug Treatment Service Value Set); if the service includes a range of dates, then use the earliest date as the date of service. Use this date for all relevant events (the IESD, negative diagnosis history and numerator events).
IESD	Index Episode Start Date. The earliest date of service for an eligible encounter during the Intake Period with a diagnosis of SUD. *For an outpatient, intensive outpatient, partial hospitalization, observation, telehealth, or ED visit (not resulting in an inpatient stay),* the IESD is the date of service. *For an inpatient stay or for detoxification that occurred during an inpatient stay,* the IESD is the date of discharge. *For detoxification* (other than detoxification that occurred during an inpatient stay), the IESD is the date of service.

	For ED or observation visits that result in an inpatient stay, the IESD is the date of the inpatient discharge (a SUD diagnosis is not required for the inpatient stay; use the diagnosis from the ED or observation visit to determine the diagnosis cohort). *For direct transfers*, the IESD is the discharge date from the last admission (a SUD diagnosis is not required for the transfer; use the diagnosis from the initial admission to determine the diagnosis cohort).
Negative Diagnosis History	A period of 60 days (2 months) before the IESD when the individual had no claims/encounters with a diagnosis of SUD. *For an inpatient stay,* use the admission date to determine the Negative Diagnosis History. *For ED or observation visits that result in an inpatient stay,* use the earliest date of service (either the ED/observation date of service or the inpatient admission date) to determine the Negative Diagnosis History. *For direct transfers,* use the first admission to determine the Negative Diagnosis History.
Direct transfer	A direct transfer is when the discharge date from the first inpatient setting precedes the admission date to a second inpatient setting by one calendar day or less. For example: An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1, is a direct transfer. An inpatient discharge on June 1, followed by an admission to an inpatient setting on June 2, is a direct transfer. An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 3, is not a direct transfer; these are two distinct inpatient stays. Use the following method to identify admissions to and discharges from inpatient settings. 3. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 4. Identify the admission and discharge dates for the stay.

Numerator:
Individuals who have Initiation of SUD treatment within 14 days of the IESD.

- If the IESD was an inpatient discharge (or an ED/observation visit that resulted in an inpatient stay), the inpatient stay is considered initiation of treatment and the individual is compliant.
- If the IESD was an opioid treatment service that bills monthly (OUD Monthly Office Based Treatment Value Set), the opioid treatment service is considered initiation of treatment and the individual is compliant.
- If the IESD was not an inpatient discharge, the individual must initiate treatment on the IESD or in the 13 days after the IESD (14 total days). Any of the following code combinations meet criteria for initiation:
- An acute or nonacute inpatient admission with a diagnosis (on the discharge claim) matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set,

Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute and nonacute inpatient admissions:

- Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
- Identify the admission date for the stay.
- IET Stand Alone Visits Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- Observation Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- IET Visits Group 1 Value Set with IET POS Group 1 Value Set and a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- IET Visits Group 2 Value Set with IET POS Group 2 Value Set and a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A telephone visit (Telephone Visit Value Set) with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An e-visit or virtual check-in (Online Assessments Value Set) with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- If the IESD was for a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set) an opioid treatment service (OUD Weekly Non-Drug Service Value Set).
- If the IESD was for a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set) an opioid treatment service (OUD Monthly Office Based Treatment Value Set).
- If the IESD was for a diagnosis of alcohol abuse or dependence (Alcohol Abuse and Dependence Value Set) a medication treatment dispensing event (Alcohol Use Disorder Treatment Medications List) or medication treatment during a visit (AOD Medication Treatment Value Set).
- If the IESD was for a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set) a medication treatment dispensing event (Opioid Use Disorder Treatment Medications List) or medication treatment during a visit (AOD Medication Treatment Value Set; OUD Weekly Drug Treatment Service Value Set).
- For all initiation events except medication treatment (AOD Medication Treatment Value Set; Alcohol Use Disorder Treatment Medications List; Opioid Use Disorder Treatment Medications List), initiation on the same day as the IESD must be with different providers in order to count.
- If an individual is compliant for the Initiation numerator for any diagnosis cohort (alcohol, opioid, other drug) or for multiple cohorts, count the individual only once in the Total Initiation numerator. The “Total” column is not the sum of the diagnosis columns.
- Exclude the individual from the denominator for both indicators (Initiation of AOD Treatment and Engagement of AOD Treatment) if the initiation of treatment event is an inpatient stay with a discharge date after November 27 of the MY.

Denominator:
Individuals who gave birth at the ACH (M1M4M5Denom_APR_DRG_Detail) within the measurement period with a new episode of substance use disorder (SUD) during the Intake Period.

Follow the steps below to identify the eligible population, which is the denominator.

Step 1: Identify the IESD. Identify all individuals in the specified age range within the attributed population who during the Intake Period had one of the following:

- An outpatient visit, telehealth, intensive outpatient visit or partial hospitalization with a diagnosis of SUD. Any of the following code combinations meet criteria:
    - IET Stand Alone Visits Value Set with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
    - IET Visits Group 1 Value Set with IET POS Group 1 Value Set and with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
    - IET Visits Group 2 Value Set with IET POS Group 2 Value Set and with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
    - OUD Weekly Non-Drug Service Value Set with Opioid Abuse and Dependence Value Set.
    - OUD Monthly Office Based Treatment Value Set with Opioid Abuse and Dependence Value Set.
    - OUD Weekly Drug Treatment Service Value Set with Opioid Abuse and Dependence Value Set.
- A detoxification visit (Detoxification Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An ED visit (ED Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An observation visit (Observation Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An acute or nonacute inpatient discharge with one of the following on the discharge claim: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute and nonacute inpatient discharges:
    1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
    2. Identify the discharge date for the stay.
- A telephone visit (Telephone Visits Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.

- An e-visit or virtual check-in (Online Assessments Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An opioid treatment service (OUD Weekly Non-Drug Service Value Set; OUD Monthly Office Based Treatment Value Set; OUD Weekly Drug Treatment Service Value Set) with a diagnosis of opioid abuse of dependence (Opioid Abuse and Dependence Value Set).

For individuals with more than one episode of AOD abuse or dependence, use the first episode.

For individuals whose first episode was an ED or observation visit that resulted in an inpatient stay, use the diagnosis from the ED or observation visit to determine the diagnosis cohort and use the inpatient discharge date as the IESD.

Step 2: Select the IESD and stratify based on age and SUD diagnosis cohort.

- If the individual has a diagnosis of alcohol abuse or dependence (Alcohol Abuse and Dependence Value Set), place the individual in the alcohol cohort.
- If the individual has a diagnosis of opioid abuse of dependence (Opioid Abuse and Dependence Value Set), place the individual in the opioid cohort.
- If the individual has a drug abuse or dependence that is neither for opioid or alcohol (Other Drug Abuse and Dependence Value Set), place the individual in the other drug cohort.

If the individual has multiple substance use diagnosis for the visit, report the individual in all SUD diagnosis stratifications for which they meet criteria.

The total is not a sum of the diagnosis cohorts. Count individuals in the total denominator rate if they had at least one alcohol, opioid or other drug abuse or dependence diagnosis during the measurement period. Report individuals with multiple diagnoses during the IESD only once for the total rate for the denominator.

Step 3: Test for Negative Diagnosis History. Exclude individuals who had a claim/ encounter with a diagnosis of SUD (AOD Abuse and Dependence Value Set), SUD medication treatment (AOD Medication Treatment Value Set) or a substance use disorder treatment medication dispensing event (Alcohol Use Disorder Treatment Medications List; Opioid Use Disorder Treatment Medications List) during the 60 days (2 months) before the IESD.

For an inpatient IESD, use the admission date to determine the 60-day Negative Diagnosis History period.

For ED or observation visits that result in an inpatient stay, use the earliest date of service (either the ED/observation date of service or the inpatient admission date) to determine the Negative Diagnosis History.

Step 4: Calculate continuous enrollment. Individuals must be continuously enrolled for 60 days (2 months) before the IESD through 47 days after the IESD (108 total days), with no gaps.

Exclusions:

- Exclude individuals who had a claim/encounter with a diagnosis of SUD (AOD Abuse and Dependence Value Set), SUD medication treatment (AOD Medication Treatment Value Set) or a substance use disorder treatment medication dispensing event (Alcohol Use Disorder Treatment Medications List; Opioid Use Disorder Treatment Medications List) during the 60 days (2 months) before the IESD.
- Exclude if used hospice during the measurement period (Hospice Encounter, Hospice Intervention Value Set).

Result:
The result is expressed as a percentage.

Improvement Direction:
Higher

Measure Deviations from Original Specifications:

Limited to the maternal health population.

Major Changes HEDIS MY 2020 and MY 2021:

- Clarified the Episode Date when detoxification occurs during an acute inpatient stay.
- Updated the step 3 instructions for ED and observation visits that result in an inpatient stay, to make them consistent with instructions in the Definitions section.
- Added value sets for opioid treatment services that are billed weekly or monthly to the denominator and numerators.
- Updated the continuous enrollment period.
- Note: In 2018 the measure steward began stratifying by SUD diagnosis cohort, alcohol abuse or dependence, opioid abuse or dependence, other drug abuse or dependence and total. Only the age stratification that includes all ages (Total) will be used for QIP-NJ

Data Elements:

- Attributed to the maternal health population
- Index episode
- Admission date
- Follow up visit category
- Follow up visit date

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances:

- http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures.aspx
- http://www.qualityforum.org/QPS/0004

Measure Collection Description

<table>
<tr><td colspan="2">Setting of Care:
Multi-setting</td><td colspan="2">Reporting Period:
Annual</td></tr>
<tr><td colspan="2">Measurement Period:
January 1, 2025 – December 31, 2025</td><td colspan="2">Baseline Period:
July 1, 2020 –December 31, 2020</td></tr>
<tr><td colspan="2">Payment Method:
P4P</td><td colspan="2">Measure Weight:
14.29%</td></tr>
<tr><td>Claim Type(s):

01, 03, 04, 14, 15, 18, 19</td><td>01 – Inpatient Hospital
02 – Long Term Care
03 – Outpatient Hospital
04 – Physician
05 – Chiropractor
06 – Home Health
07 – Transportation
08 – Vision</td><td>09 – Supplies, DME
10 – Podiatry
11 – Dental
12 – Pharmacy
13 – EPDST/Healthstart
14 – Institutional Crossover
15 – Professional Crossover</td><td>16 – Lab
17 – Prosthetic and Orthotics
18 – Independent Clinic
19 – Psychologists
21 – Optometrists
22 – Mid Level Practitioner
23 – Hearing Aid</td></tr>
<tr><td colspan="2">Continuous Eligibility Period: Yes</td><td>Risk Adjustment: No</td><td>Sampling: No</td></tr>
<tr><td colspan="4">Continuous Eligibility/ Risk Adjustment/ Sampling Methodology: Individuals must be continuously enrolled without any gaps 60 days (2 months) before the IESD through 48 days after the IESD. Following, November 14 is the last day in the calendar year that an individual is eligible for consideration into this measurement cohort. No sampling permitted.</td></tr>
</table>

Measure M006: Timely Transmission of Transition Record (Maternal Health)

Measure Description:
Percentage of individuals, 18 through 64 years of age, discharged from a birth admission to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge.

Data Source:	NQF #:
Chart/EHR	**Based on 0648**
Measure Steward:	Measure Steward Version:
AMA-PCPI	**June 28, 2017**

Statewide Benchmark:
80%

Measure Calculation Description

Numerator:
Individuals who had a birth admission discharge for whom a transition record was transmitted to the facility or primary care physician or other health care professional designated for follow-up care within 24 hours of discharge.

Transition record - a core, standardized set of data elements related to patient's diagnosis, treatment, and care plan that is discussed with and provided to patient in printed or electronic format at each transition of care, and transmitted to the facility/physician/other health care professional providing follow-up care. Electronic format may be provided only if acceptable to patient.

Transmitted - transition record may be transmitted to the facility or physician or other health care professional designated for follow-up care via fax, secure e-mail, or mutual access to an EHR.

Primary physician or other health care professional designated for follow-up care - may be a designated PCP, medical specialist, or other physician or health care professional.

Denominator:
Of the attributed Maternal health population, individuals 18 years and older discharged from an inpatient facility (Table BH09M06_01a) to home/self-care or any other designated site of care (Table BH09M06_01b) with a Maternal Health Diagnosis (Table M06_00) or Procedure (Table M03_Deliveries)

Exclusions:
- Individuals who expired (Table BH09M06_02)
- Individuals who left against medical advice or discontinued care (Table BH09M06_02)

Result:
The result is expressed as a percentage.

Improvement Direction:
Higher

Measure Deviations from Original Specifications:

- Added limitation to the maternal health population.
- Limited eligible population to 18-64 years of age.

Data Elements:

- Attributed to the maternal health population
- Diagnosis/Procedure of Care (birth admission)
- Bill Type Code
- Revenue Code
- Patient Discharge Status Code
- Discharge Date
- Patient Discharge Summary Transmission Date
- Race
- Ethnicity

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances:

- http://www.qualityforum.org/QPS/0648

Measure Collection Description		
Setting of Care: **Inpatient**		Reporting Period: **Annual**
Measurement Period: **January 1, 2025 – December 31, 2025**		Baseline Period: **July 1, 2020 –December 31, 2020**
Payment Method: **P4P**		Measure Weight: **14.29%**
Continuous Eligibility Period: **No**	Risk Adjustment: **No**	Sampling: **Yes**
Continuous Eligibility / Sampling Methodology: **Sampling is permitted.**		

Data Submission Requirements:

1. All data must be submitted for performance eligible individuals only, in accordance with the sampling guidance
2. Enter all relevant data, including multiple events, per eligible individual

3. Any individuals who have become ineligible (e.g., no longer enrolled in MMC) should be removed from all results
4. Any additional information may be added to the submission comments in the "Standard Reporting Template"
5. Please refer to the "Standard Reporting Template" for more detail on submission requirements

Measure M007: Treatment of Severe Hypertension (SHTN)

Measure Description:
The percentage of pregnant or postpartum birthing individuals aged 18 to 55 years old with a severe hypertensive episode that is treated within one hour by a recommended first-line agent.

Data Source:	NQF #:
Chart/EHR	**N/A**
Measure Steward:	Measure Steward Version:
Alliance for Innovation on Maternal Health (AIM)	**--**

Statewide Benchmark:
80%

Measure Calculation Description

Numerator:
Among the denominator, cases that were treated within one hour of SHTN diagnosis with a first-line agent, including:

- IV Labetalol,
- IV Hydralazine,
- Immediate release oral Nifedipine[14]

Recommended dispensing intervals:

- IV Labetalol = 20 minutes
- IV Hydralazine = 10 minutes
- Immediate release oral Nifedipine = 10 minutes

SHTN may be reflected in either the systolic or diastolic blood pressure:

- A systolic blood pressure (BP) >= 160 mm Hg or
- A diastolic blood pressure >=110 mm Hg reading

First-line agents (Table M07_00) must be dispensed within one hour of the first reading of SHTN. IV Labetalol and IV hydralazine are the preferred first-line agents although oral nifedipine (a calcium channel blocker) is favored if intravenous therapy is unavailable. Second-line interventions such as anesthesia and magnesium sulfate are rarely used and therefore, not recommended, respectively.

Denominator:

[14] The Society for Maternal Fetal Medicine specifically states that extended release nifedipine is not a standard treatment for SHTN episodes.

Number of birthing individuals with persistent new-onset[15] SHTN, greater than or equal to 20 weeks gestation through 7 days postpartum with:

- An ICD-10-CM Principal Diagnosis or Other Diagnosis Code for Pre-existing or Gestational Hypertension, Eclampsia/Pre-eclampsia (Table M07_01)

AND

- Two or more readings of SHTN defined as
    - A systolic blood pressure >= 160 mm Hg or
    - A diastolic blood pressure >=110 mm Hg reading

That are taken at greater than or equal to 15-minute intervals and no more than 60 minutes apart.

Exception: If a first-line hypertensive agent is administered after the first reading and prior to the second reading—even if the second reading does not indicate SHTN*—the patient will be both numerator- and denominator-compliant. There must be a second reading reported at greater than or equal to 15-minutes and no more than 60 minutes from the first SHTN reading for denominator-compliance.

For this measure, records should be reported at the procedure level, not the individual level. For an individual to be included in the denominator the individual must have at least 2 BP readings, but the hospital may report up to 5 consecutive BP readings.

Include all individual BP readings.

Exclusion:

- Birthing individuals with an exacerbation of chronic hypertension (Table M07_02). Chronic Hypertension is defined by the American College of Obstetricians and Gynecologists (ACOG) as a diagnosis of hypertension (systolic blood pressure ≥ 140 mm Hg or diastolic blood pressure ≥ 90 mm Hg) prior to pregnancy or at fewer than 20 weeks gestation.
- Any SHTN instances that occur:
    - Prior to 20 weeks of pregnancy or
    - After 7 days postpartum
- An ICD-10-CM Principal Diagnosis or Other Diagnosis Code for Gestational Edema or Unspecified Maternal Hypertension (Table M07_02)

Result:
The result is expressed as a percentage.

Improvement Direction:
Higher

Measure Deviations from Original Specifications:

- First-line hypertensive administration timing update to align with ACOG guidelines.

[15] New onset is defined as the first instance of the individual presenting at the facility. Do not count BP readings taken in the office setting.

Data Elements:

- Attributed to the maternal health population
- The maternal medical record will be used to validate diagnosis and treatment.

Measure Collection Description			
Setting of Care: **Inpatient or Emergency Department**		Reporting Period: **Annual**	
Measurement Period: **January 1, 2025 – December 31, 2025**		Baseline Period: **July 1, 2020 –December 31, 2020**	
Payment Method: **P4P**		Measure Weight: **14.29%**	
Claim Type(s): **01** **03 (for Emergency Department only)**	**01** – Inpatient Hospital **02** – Long Term Care **03** – Outpatient Hospital **04** – Physician **05** – Chiropractor **06** – Home Health **07** – Transportation **08** – Vision	**09** – Supplies, DME **10** – Podiatry **11** – Dental **12** – Pharmacy **13** – EPDST/Healthstart **14** – Institutional Crossover **15** – Professional Crossover	**16** – Lab **17** – Prosthetic and Orthotics **18** – Independent Clinic **19** – Psychologists **21** – Optometrists **22** – Mid Level Practitioner **23** – Hearing Aid
Continuous Eligibility Period: **No**	Risk Adjustment: **No**	Sampling: **Yes**	

Continuous Eligibility/ Risk Adjustment/ Sampling Methodology: **Sampling is permitted.**

Data Submission Requirements

As this measure examines multiple instances of blood pressure readings per individual, it is important to provide *time of each separate procedure in addition to the date*. See SRT for example scenarios.

Data File Format Instructions

1. All data must be submitted for performance eligible individuals only, in accordance with the sampling guidance.
2. Enter all relevant data, including multiple events, per eligible Individual
3. Any individuals who have become ineligible (e.g., no longer enrolled in MMC) should be removed from all results
4. Any additional information may be added to the submission comments in the "Standard Reporting Template"
5. Please refer to the "Standard Reporting Template" for more detail on submission requirements

Measure M008: 3-Item Care Transitions Measure (CTM-3)

Measure Description:
The CTM-3 is a hospital level measure of performance that reports the average individual reported quality of preparation for self-care response among individuals aged 18 years and older discharged from general ACHs within the past 30 days.

Data Source:	NQF #:
Instrument Based Data	**Based on 0228**
Measure Steward:	Measure Steward Version:
University of Colorado Denver Anschutz Medical Campus	**December 16, 2019**
Statewide Benchmark:	
N/A	

Measure Calculation Description

Numerator:
The numerator is the hospital level sum of the CTM-3 scores for all eligible sampled individuals. Hospitals may submit results from Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) (Please note: effective calendar year 2025: CMS removed these questions from the HCAHPS – if your facility has added them in as custom questions to the HCAHPS you may use those) and/or Experience of Care and Health Outcomes (ECHO) surveys in lieu of administering an independent survey.

The items and response options are as follows:

1. The hospital staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left the hospital.
   ☐ Strongly Disagree
   ☐ Disagree
   ☐ Agree
   ☐ Strongly Agree

2. When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.
   ☐ Strongly Disagree
   ☐ Disagree
   ☐ Agree
   ☐ Strongly Agree

3. When I left the hospital, I clearly understood the purpose for taking each of my medications.

☐ Strongly Disagree

☐ Disagree

☐ Agree

☐ Strongly Agree

☐ I was not given any medication when I left the hospital

There are 5 response options for Q1 and Q2: Strongly Disagree = 1, Disagree = 2, Agree = 3, Strongly Agree = 4, Don't know/Don't remember/Not applicable = 0

There are 5 response options for Q3: Strongly Disagree = 1, Disagree = 2, Agree = 3, Strongly Agree = 4, I was not given any medication when I left the hospital = 5 (for HCAHPS CTM-3 only), Don't Know/Don't Remember/Not Applicable = 0 (Standalone CTM-3 only)

The range of total raw score per individual is 0 to 13.

Denominator:
Of the attributed maternal health population, the number of eligible sampled adults discharged from a general ACH.

Exclusions:

- Individuals who died in the hospital
- Individuals who did not stay at least one night in the hospital

Please note: Reporting on this measure is optional for MY5

Result:
The result is expressed as an average score.

Improvement Direction:
Higher

Measure Deviations from Original Specifications:

- Permit the submission of data from HCAHPS surveys in addition to independent survey design.

Data Elements:

- Attributed to the maternal health population
- Survey date
- Survey tool result
- Follow up plan
- Exclusionary diagnosis or other reason (if applicable)

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances:

- http://www.qualityforum.org/QPS/0228

Measure Collection Description	
Setting of Care: **Inpatient**	Reporting Period: **Annual**
Measurement Period: **January 1, 2025 – December 31, 2025**	Baseline Period: **July 1, 2020 –December 31, 2020**
Payment Method: **N/A**	Measure Weight: **N/A**
Risk Adjustment: **No**	Sampling: **Yes**

Sampling or Risk Adjustment Methodology: **Sampling is permitted.**

Survey Administration

- Survey should be administered between 48 hours and 30 days post discharge, regardless of mode of administration.
- No proxies are permitted to respond on behalf of patients. Someone other than the person who received care is permitted to read the questions to the respondent and/or record the responses.
- May be administered as a stand-alone instrument or combined with other hospital-specific questions.
- Data collection shall be closed out no later than 4 weeks following start of data collection for that respondent.
- Mode of delivery:
    1. Mail-only – includes CTM-3 only or combined with other hospital-specific questions. With cover letter that may be tailored but must include language indicating the purpose of the survey, explanation that participation is voluntary, and statement that the individual's health benefits will not be affected by participation.
    2. Telephone-only – Standardized script should be used, interviewers administering the surveys must be trained, and must attempt to contact respondent at least five times unless respondent refuses to complete the survey.
    3. Mixed mode of mail and telephone – Specifications for mail-only and telephone-only apply, except second mailing is not required and only non-respondents shall be contacted by telephone at least five times as per telephone only mode.
    4. Electronic/Mixed mode of email, text, and phone call – Submission of data is allowed if secure transmission protocols exist and if data may be appropriately mapped into respective answers.

Where CTM-3 questions or survey guidance differ from CMS guidance for HCAHPS, hospitals submitting HCAHPS results should defer to CMS guidance.

Note: any inquiries about the mode of delivery for the survey should be directed to QIP-NJ@pcgus.com.

Data Submission Requirements

1. All data must be submitted for performance eligible individuals only, in accordance with the sampling guidance
2. Enter all relevant data, including multiple survey events, per eligible individual
3. Any individuals who have become ineligible (e.g., no longer enrolled in MMC) should be removed from all results
4. Any additional information may be added to the submission comments in the "Standard Reporting Template"
5. Please refer to the "Standard Reporting Template" for more detail on submission requirements

Measure M009: Use of a Standardized Screening Tool for Social Determinants of Health

Measure Description:	
Of the birthing individuals who delivered at the hospital during the measurement period, the percent of individuals who have received a screening using a validated tool including the five SDOH domains identified by the State: Housing, Food Security, Transportation, Social Supports, and Domestic Violence.	
Data Source: **Instrument Based**	NQF #: **N/A**
Measure Steward: **NJ DOH**	Measure Steward Version: **July 1, 2021**
Statewide Benchmark: **N/A**	

Measure Calculation Description

Numerator

Of the birthing individuals who delivered at the hospital during the measurement period, those that received a screening using a validated tool including SDOH domains identified by the State: Housing, Food Security, Transportation, Social Supports, and Domestic Violence.

Domains required by the State:

- Housing
- Food Security
- Transportation
- Social Supports
- Domestic Violence Status

Validated screening tools:

1. AAFP: Social Determinants of Health
2. NJ Perinatal Risk Assessment (PRA)

Denominator:

The maternal health population attributed to the facility.

Result:

The result is expressed as a percentage.

Improvement Direction:

Higher

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances:

- AAFP: Social Determinants of Health
- NJ Perinatal Risk Assessment (PRA)

Measure Collection Description	
Setting of Care: **Multi-setting (IP, OP, ED)**	Reporting Period: **Annual**
Measurement Period: **January 1, 2025 – December 31, 2025**	Baseline Period: **July 1, 2020 –December 31, 2020**
Payment Method: **N/A**	Measure Weight: **N/A**
Risk Adjustment: **No**	Sampling: **Yes**

Sampling Methodology: **Sampling is permitted.**

Data Submission Requirements

1. All data must be submitted for performance eligible individuals only, in accordance with the sampling guidance
2. Enter all relevant data, including multiple screening events, per eligible individual
3. Any individuals who have become ineligible (e.g., no longer enrolled in MMC) should be removed from all results
4. Any additional information may be added to the submission comments in the "Standard Reporting Template"
5. Please refer to the "Standard Reporting Template" for more detail on submission requirements

Measure M010: Reducing Disparities and Improving Patient Experience Through Targeted Training

Measure Description:
The percentage of hospital staff who have received at least one implicit bias training during the measurement year and the percentage of hospital staff who have received at least one Social Determinants of Health (SDOH) training during the measurement year.

Data Source:	NQF #:
Administrative	**N/A**
Measure Steward:	Measure Steward Version:
NJ DOH	**N/A**

Statewide Target:
N/A

Measure Calculation Description

Numerator:
Number of hospital staff that have received at least one training related to implicit bias **AND** at least one training related to SDOH during the MY.

SDOH training must meet the following criteria[16,17,,18:]

- Describing and addressing the five (5) key areas of SDOH -- education, economic stability, neighborhood and built environment, health and health care, and social and community context – and understanding how each can impact health outcomes;
- Exploring the relationship between social determinants of health and health disparities, including specific examples; and
- An overview of the SDOH tools currently in place at the hospital including, how to access the tools, who is required to complete the tools, and what process is in place at the hospital if a patient screens positive.

As part of a hospital's **overall SDOH program**, DOH recommends the following considerations:

- Identifying social determinants of health during clinical encounters and ensuring community health assessments (CHA) include SDOH measures and engaging communities and multi-sectoral partners.
- Identifying how hospitals and their partners can consider how conditions in the places where people live, learn, work, and play affect a wide range of health risks and outcomes, which should

[16] "The Social Determinants of Health: The Root of the Health Center Program." *The Social Determinants of Health Academy*. 23 Jan. 2020. Foundational Trainings — The SDOH Academy
[17] "CDC Programs Addressing Social Determinants of Health." *Centers for Disease Control and Prevention*. 14 Oct. 2021. CDC Programs Addressing SDOH | Social Determinants of Health | CDC
[18] Dustman, Renee. "Free Online Training in Social Determinants of Health." *AAPC*. 20 Jun. 2019. Free Online Training on Social Determinants of Health - AAPC Knowledge Center

include a system for monitoring health outcomes, collecting data, developing policies, creating an informed and competent workforce, providing appropriate linkages to care, and a method for evaluating effectiveness of processes and if/as needed, implementing quality improvement strategies.

- Implementing innovative solutions, evidence-based tools, and actions to address SDOH considerations and the resulting health inequities, which be incorporated throughout all aspects of health care services and various delivery modalities.
- Creating broader awareness of how key health care practices can better incorporate consideration of SDOH, inclusive of incorporating SDOH measures as basis for addressing community health problems and inequities and finding ways to mobilize community partnerships.
- Sharing information and best practices as to how health care practitioners can transform and strengthen their capacity and impact to advance health equity.

Implicit Bias training must meet the following criteria[19]:

- identifying previous and current unconscious biases and misinformation when providing perinatal treatment and care to, or interacting with, pregnant persons;
- identifying environmental, personal, interpersonal, institutional, and cultural barriers to inclusion;
- information on the effects of historical and contemporary exclusion and oppression of minority communities;
- information about cultural identity across racial, ethnic, and other marginalized groups;
- information about communicating more effectively across racial, ethnic, religious, and gender identities;
- information about reproductive justice;
- a discussion on power dynamics and organizational decision-making and their effects on explicit and implicit bias
- a discussion on inequities and racial, ethnic and other disparities within the field of perinatal care, and how explicit and implicit bias may contribute to pregnancy-related deaths and maternal and infant health outcomes; and
- corrective measures to decrease explicit and implicit bias at the interpersonal and institutional levels.

Denominator:
Hospital-employed (including per diem) healthcare professionals and patient-facing support staff that interact with maternal health patients. At their discretion, hospitals may include hospital-employed, community-based staff in the denominator, however, if community-based staff are included, they must be included in the denominator every year. See SRT Frequently Asked Questions for detailed information about whom to include/exclude.

Exclusions: Employees hired between December 1 – December 31 of the MY.

[19] Senate Bill 703/Assembly Bill 1079, Approved P.L.2021, c.79 (state.nj.us)

Result:
The result is expressed as a percentage.

Improvement Direction:
Higher

Data Elements:

- Hospital Staff first name
- Hospital Staff last name
- Implicit Bias Training Course Name
- Social Determinants of Health (SDOH) Training Course Name
- Date of Course(s)
- EmployeeID or other unique identifier for hospital staff

Measure Collection Description		
Setting of Care: **N/A**	Reporting Period: **Annual**	
Measurement Period: **January 1, 2025 – December 31, 2025**	Baseline Period: **January 1, 2022 –December 31, 2022**	
Payment Method: **NA**	Measure Weight: **NA**	
Continuous Eligibility Period: **N/A**	Risk Adjustment: **No**	Sampling: **N/A**

Continuous Eligibility / Sampling Methodology: **Does not apply / no sampling permitted.**

Data Submission Requirements:

1. Enter all relevant data, including multiple training events, per eligible individual
2. Any additional information, including which tool was used, should be added to the submission comments in the "Standard Reporting Template"
3. Please refer to the "Standard Reporting Template" for more detail on submission requirements

Appendix A: Value Code Sets by Measure

Measure Change Log Summary

The purpose of the Measure Change Log is to clarify major measure modifications between each draft release of the Databook and Value Set Compendium (VSC). Major measure modifications are defined as those changes, including addition or deletion of value sets, that impact the measure calculations. Below indicates those implemented in Databook version 5.0 and 5.1, updating version 4.1.

- These changes are in conjunction with the updates to VSC 5.0 and VSC 5.1
- Please consult the Change Log Tab in the VSC to understand code additions, removals, adjustments, and/or references.

A. Behavioral Health Measures Grid

Measure #	Measure Name & NQF #	Measure Steward	Data Source	Major Modifications v5.0 and v5.1
BH01	30 Day All-Cause Unplanned Readmission Following Psychiatric Inpatient Hospitalization- NQF #2860	CMS	MMIS	• No major changes
BH02	Follow-Up After Hospitalization for Mental Illness – 30-days Post-Discharge- NQF #0576	NCQA	MMIS	• No major changes
BH03	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (30 day) – NQF #3488	NCQA	MMIS	• No major changes
BH04	Follow-Up After Emergency Department Visit for Mental Illness (30 day) – NQF #3489	NCQA	MMIS	• No major changes
BH05	Initiation of Alcohol and Other Drug Abuse or	NCQA	MMIS	• See VSC v5 for added numerator-compliant codes

	Dependence Treatment – NQF #0004			
BH06	Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - NQF #0004	NCQA	MMIS	• See VSC v5 for added numerator-compliant codes
BH07	Preventative Care and Screening: Screening for Depression and Follow-Up – NQF #0418	CMS	Chart/EHR	• No major changes
BH08	Substance Use Screening and Intervention Composite – NQF #2597	ASAM	Chart/EHR	• No major changes
BH09	Timely Transmission of the Transition Record- NQF #0648	AMA-PCPI	Chart/EHR	• No major changes
BH10	3-Item Care Transitions Measure (CTM-3)	University of Colorado Denver Anschutz Medical Campus	Instrument	• Reporting Optional for MY5
BH11	Use of a Standardized Screening Tool for Social Determinants of Health	NJ DOH	Instrument	• No major changes
BH12	Reducing Disparities and Improving Patient Experience Through Targeted Training	NJ DOH	Instrument	• No major changes

B. Maternal Health Measures Grid

Measure #	Measure Name & NQF #	Measure Steward	Data Source	Major Modifications v5 and v5.1
M001	Severe Maternal Morbidity (SMM)	CDC	MMIS	• No major changes
M002	PC-02 Cesarean Birth - NQF #0471	Joint Commission	Chart/EHR	• See VSC v5.1 for added exclusions
M003	Postpartum Depression Screening – NQF #1401	NCQA	Chart/EHR	• See VSC v5 for added numerator-compliant codes
M004	Postpartum Care - NQF #1517	NCQA	MMIS	• See VSC v5 for added numerator-compliant codes
M005	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment in Pregnant Women -NQF #0004	NCQA	MMIS	• See VSC v5 for added numerator-compliant codes
M006	Timely Transmission of the Transition Record- NQF #0648	AMA-PCPI	Chart/EHR	• No major changes
M007	Treatment of Severe Hypertension	Alliance for Innovation on Maternal Health (AIM)	Chart/EHR	• No major changes
M008	3-Item Care Transitions Measure (CTM-3)	University of Colorado Denver Anschutz Medical Campus	Instrument	• Reporting Optional for MY5

M009	Use of a Standardized Screening Tool for Social Determinants of Health	NJ DOH	Instrument	• No major changes
M010	Reducing Disparities and Improving Patient Experience Through Targeted Training	NJ DOH	Instrument	• No major changes

Measure BH01: 30 Day All-Cause Unplanned Readmission Following Psychiatric Inpatient Hospitalization

Table Name	Table Description	Measure Component
Table BH01_00	AHRQ Modified CCS-Mapped to ICD-10-CM Psychiatric Principal Discharge Diagnosis categories	Denominator
Table BH01_01	AHRQ Modified CCS-Mapped to ICD-10-PCS Procedure categories that are always planned	Denominator Exclusion
Table BH01_02	AHRQ Modified CCS-Mapped to ICD-10-CM Diagnosis categories that are always planned	Denominator Exclusion
Table BH01_03	AHRQ Modified CCS-Mapped to ICD-10-CM Procedure categories that are potentially planned	Denominator Exclusion
Table BH01_04	AHRQ Modified CCS-Mapped to ICD-10-CM Diagnosis categories that are considered planned if not coinciding with principal discharge diagnosis or complication	Denominator Exclusion

***The numerator is defined by filtering out "always planned" and "potentially planned" diagnoses and procedures**

Measure BH02: Follow-up After Hospitalization for Mental Illness (FUH) – 30 Days Post-Discharge

Value Set Name	Value Set OID	Measure Component
NJ Place of Service Value Set	N/A	Numerator
Mental Health Follow-Up Revenue & CPT/HCPCS Value Set	N/A	Numerator
Adult Mental Health Rehabilitation (AMHR) Value Set	N/A	Denominator Exclusion
Hospice Encounter	2.16.840.1.113883.3.464.1004.1761	Denominator Exclusion
Hospice Intervention	2.16.840.1.113883.3.464.1004.1762	Denominator Exclusion
Nonacute Inpatient Stay	2.16.840.1.113883.3.464.1004.1398	Denominator Exclusion
Discharge Status Codes	N/A	Denominator Exclusion
Inpatient Stay	2.16.840.1.113883.3.464.1004.1395	Denominator
Intentional Self-Harm	2.16.840.1.113883.3.464.1004.1468	Denominator
Mental Health Diagnosis	2.16.840.1.113883.3.464.1004.1178	Denominator
Mental Illness	2.16.840.1.113883.3.464.1004.1179	Denominator
Psychiatric Collaborative Care Management	2.16.840.1.113883.3.464.1004.2261	Numerator

Measure BH03: Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD) (30 day)

Value Set Name	Value Set OID	Measure Component
NJ Place of Service Value Set	N/A	Numerator
AOD Treatment Service Follow-up CPT/HCPCS Value Set	N/A	Numerator
Telephone Visits	2.16.840.1.113883.3.464.1004.1246	Numerator
ED	2.16.840.1.113883.3.464.1004.1086	Denominator
AOD Abuse and Dependence	2.16.840.1.113883.3.464.1004.1013	Denominator
Hospice Encounter	2.16.840.1.113883.3.464.1004.1761	Denominator Exclusion
Hospice Intervention	2.16.840.1.113883.3.464.1004.1762	Denominator Exclusion
Inpatient Stay	2.16.840.1.113883.3.464.1004.1395	Denominator Exclusion
Observation	2.16.840.1.113883.3.464.1004.1191	Denominator Exclusion
Additional Bill Type Codes	N/A	Numerator
Discharge Status Code	N/A	Denominator Exclusion

Measure BH04: Follow-Up After Emergency Department Visit for Mental Illness (FUM) (30 day)

Value Set Name	Value Set OID	Measure Component
NJ Place of Service Value Set	N/A	Numerator
Mental Health Follow-Up Revenue & CPT/HCPCS Value Set	N/A	Numerator
Adult Mental Health Rehabilitation (AMHR) Value Set	N/A	Denominator Exclusion
Hospice Encounter	2.16.840.1.113883.3.464.1004.1761	Denominator Exclusion
Hospice Intervention	2.16.840.1.113883.3.464.1004.1762	Denominator Exclusion
Inpatient Stay	2.16.840.1.113883.3.464.1004.1395	Denominator Exclusion
ED	2.16.840.1.113883.3.464.1004.1086	Denominator
Intentional Self-Harm	2.16.840.1.113883.3.464.1004.1468	Denominator
Mental Health Diagnosis	2.16.840.1.113883.3.464.1004.1178	Denominator
Mental Illness	2.16.840.1.113883.3.464.1004.1179	Denominator
Discharge Status Code	N/A	Denominator Exclusion

Measure BH05: Initiation of Alcohol and Other Drug Abuse or Dependence Treatment (IET – I)

*For Medication Assisted Treatment, additional value and code sets are provided

Value Set Name	Value Set OID	Measure Component
Alcohol Abuse and Dependence	2.16.840.1.113883.3.464.1004.1424	Denominator
AOD Abuse and Dependence	2.16.840.1.113883.3.464.1004.1013	Denominator
AOD Medication Treatment	2.16.840.1.113883.3.464.1004.2017	Denominator Exclusion (if dispensing event during 60 d prior to IESD)
Detoxification	2.16.840.1.113883.3.464.1004.1076	Denominator (combined with Dependence v.s.)
ED	2.16.840.1.113883.3.464.1004.1086	Denominator (combined with Dependence v.s.)
Hospice Encounter	2.16.840.1.113883.3.464.1004.1761	Denominator Exclusion
Hospice Intervention	2.16.840.1.113883.3.464.1004.1762	Denominator Exclusion
IET POS Group 1	2.16.840.1.113883.3.464.1004.1129	Denominator (combined with Dependence v.s.)
IET POS Group 2	2.16.840.1.113883.3.464.1004.1130	Denominator (combined with Dependence v.s.)
IET Stand Alone Visits	2.16.840.1.113883.3.464.1004.1131	Numerator (combined with Dependence v.s.)
IET Visits Group 1	2.16.840.1.113883.3.464.1004.1132	Numerator (combined with Dependence v.s.)
IET Visits Group 2	2.16.840.1.113883.3.464.1004.1133	Numerator (combined with Dependence v.s.)
Inpatient Stay	2.16.840.1.113883.3.464.1004.1395	Numerator and Denominator
Observation	2.16.840.1.113883.3.464.1004.1191	Numerator (combined with Dependence v.s.)
Online Assessments	2.16.840.1.113883.3.464.1004.1446	Denominator (combined with Dependence v.s.)
Opioid Abuse and Dependence	2.16.840.1.113883.3.464.1004.1425	Denominator
Other Drug Abuse and Dependence	2.16.840.1.113883.3.464.1004.1426	Denominator
OUD Monthly Office Based Treatment	2.16.840.1.113883.3.464.1004.2220	Denominator (combined with Dependence v.s.)
OUD Weekly Drug Treatment Service	2.16.840.1.113883.3.464.1004.2221	Denominator (combined with Dependence v.s.)
OUD Weekly Non-Drug Service	2.16.840.1.113883.3.464.1004.2222	Denominator (combined with Dependence v.s.)

Telephone Visits	2.16.840.1.113883.3.464.1004.1246	Denominator (combined with Dependence v.s.)

***Opioid Use Disorder Treatment Medications List**

Value Set Name	Value Set OID	Measure Component
Buprenorphine Implant	2.16.840.1.113883.3.464.1004.1970	Denominator Exclusion (if dispensing event during 60 d prior to IESD)
Buprenorphine Injection	2.16.840.1.113883.3.464.1004.1969	Denominator Exclusion (if dispensing event during 60 d prior to IESD)
Buprenorphine Naloxone	2.16.840.1.113883.3.464.1004.1971	Denominator Exclusion (if dispensing event during 60 d prior to IESD)
Buprenorphine Oral	2.16.840.1.113883.3.464.1004.1968	Denominator Exclusion (if dispensing event during 60 d prior to IESD)
Buprenorphine Oral Weekly	2.16.840.1.113883.3.464.1004.2219	Denominator Exclusion (if dispensing event during 60 d prior to IESD)
Methadone Oral	2.16.840.1.113883.3.464.1004.1972	Denominator Exclusion (if dispensing event during 60 d prior to IESD)
Methadone Oral Weekly	2.16.840.1.113883.3.464.1004.2218	Denominator Exclusion (if dispensing event during 60 d prior to IESD)
Naltrexone Injection	2.16.840.1.113883.3.464.1004.1967	Denominator Exclusion (if dispensing event during 60 d prior to IESD)

***Alcohol Use Disorder Treatment Medications List**

Value Set Name	Value Set OID	Measure Component
Aldehyde dehydrogenase inhibitors	N/A	Denominator Exclusion (if dispensing event during 60 d prior to IESD)
Antagonist	N/A, 2.16.840.1.113883.3.464.1004.1967	Denominator Exclusion (if dispensing event during 60 d prior to IESD)
Other	N/A	Denominator Exclusion (if dispensing event during 60 d prior to IESD)

Measure BH06: Engagement in Alcohol and Other Drug Abuse or Dependence Treatment (IET – E)

*For Medication Assisted Treatment, additional value and code sets are provided

Value Set Name	Value Set OID	Measure Component
Alcohol Abuse and Dependence	2.16.840.1.113883.3.464.1004.1424	Denominator
AOD Abuse and Dependence	2.16.840.1.113883.3.464.1004.1013	Denominator
AOD Medication Treatment	2.16.840.1.113883.3.464.1004.2017	Denominator Exclusion (if dispensing event during 60 d prior to IESD)
Detoxification	2.16.840.1.113883.3.464.1004.1076	Denominator (combined with Dependence v.s.)
ED	2.16.840.1.113883.3.464.1004.1086	Denominator (combined with Dependence v.s.)
Hospice Encounter	2.16.840.1.113883.3.464.1004.1761	Denominator Exclusion
Hospice Intervention	2.16.840.1.113883.3.464.1004.1762	Denominator Exclusion
IET POS Group 1	2.16.840.1.113883.3.464.1004.1129	Denominator (combined with Dependence v.s.)
IET POS Group 2	2.16.840.1.113883.3.464.1004.1130	Denominator (combined with Dependence v.s.)
IET Stand Alone Visits	2.16.840.1.113883.3.464.1004.1131	Numerator (combined with Dependence v.s.)
IET Visits Group 1	2.16.840.1.113883.3.464.1004.1132	Numerator (combined with Dependence v.s.)
IET Visits Group 2	2.16.840.1.113883.3.464.1004.1133	Numerator (combined with Dependence v.s.)
Inpatient Stay	2.16.840.1.113883.3.464.1004.1395	Numerator and Denominator
Observation	2.16.840.1.113883.3.464.1004.1191	Numerator (combined with Dependence v.s.)
Online Assessments	2.16.840.1.113883.3.464.1004.1446	Denominator (combined with Dependence v.s.)
Opioid Abuse and Dependence	2.16.840.1.113883.3.464.1004.1425	Denominator
Other Drug Abuse and Dependence	2.16.840.1.113883.3.464.1004.1426	Denominator
OUD Monthly Office Based Treatment	2.16.840.1.113883.3.464.1004.2220	Denominator (combined with Dependence v.s.)
OUD Weekly Drug Treatment Service	2.16.840.1.113883.3.464.1004.2221	Denominator (combined with Dependence v.s.)
OUD Weekly Non-Drug Service	2.16.840.1.113883.3.464.1004.2222	Denominator (combined with Dependence v.s.)

Telephone Visits	2.16.840.1.113883.3.464.1004.1246	Denominator (combined with Dependence v.s.)

***Opioid Use Disorder Treatment Medications List**

Value Set Name	Value Set OID	Measure Component
Buprenorphine Implant	2.16.840.1.113883.3.464.1004.1970	Denominator Exclusion (if dispensing event during 60 d prior to IESD)
Buprenorphine Injection	2.16.840.1.113883.3.464.1004.1969	Denominator Exclusion (if dispensing event during 60 d prior to IESD)
Buprenorphine Naloxone	2.16.840.1.113883.3.464.1004.1971	Denominator Exclusion (if dispensing event during 60 d prior to IESD)
Buprenorphine Oral	2.16.840.1.113883.3.464.1004.1968	Denominator Exclusion (if dispensing event during 60 d prior to IESD)
Buprenorphine Oral Weekly	2.16.840.1.113883.3.464.1004.2219	Denominator Exclusion (if dispensing event during 60 d prior to IESD)
Methadone Oral	2.16.840.1.113883.3.464.1004.1972	Denominator Exclusion (if dispensing event during 60 d prior to IESD)
Methadone Oral Weekly	2.16.840.1.113883.3.464.1004.2218	Denominator Exclusion (if dispensing event during 60 d prior to IESD)
Naltrexone Injection	2.16.840.1.113883.3.464.1004.1967	Denominator Exclusion (if dispensing event during 60 d prior to IESD)

***Alcohol Use Disorder Treatment Medications List**

Value Set Name	Value Set OID	Measure Component
Aldehyde dehydrogenase inhibitors	N/A	Denominator Exclusion (if dispensing event during 60 d prior to IESD)
Antagonist	N/A, 2.16.840.1.113883.3.464.1004.1967	Denominator Exclusion (if dispensing event during 60 d prior to IESD)
Other	N/A	Denominator Exclusion (if dispensing event during 60 d prior to IESD)

Measure BH07: Preventative Care and Screening: Screening for Depression and Follow-Up (PDS)

Table Name	Table Description	Measure Component
Table BH07_00	ED and Outpatient Hospital Revenue & CPT/HCPCS Value Set	Denominator
Table BH07_01	Codes to Document Depression Screen	Numerator
Table BH07_02a	Codes for Exclusionary Diagnoses	Denominator Exclusion
Table BH07_02b	Codes for Hospice	Denominator Exclusion
Table BH07_02c	Adult Mental Health Rehabilitation (AMHR) Value Set	Denominator Exclusion
Table BH07_03	Codes for Validated Screen Tools	Numerator

Code sets for non-claims-based measures are provided as guidance for participating hospitals, but may not encompass all codes used by participating hosspitals and/or fully align with hospital- or system-specific chart/EHR documentation practices. The State is committed to working in close partnership with participating hospitals and providing technical assistance. Please submit any hospital- or system-specific questions via email to QIP-NJ@pcgus.com.

Measure BH08: Substance Use Screening and Intervention Composite

BH08_00 Value Set: Health Visits

Value Set OID	Value Set Name	Measure Component
Annual Wellness Visit	2.16.840.1.113883.3.526.2.1363	Numerator

BH08_00 Value Set: Screening Tools & SBIRT

Value Set OID	Value Set Name	Measure Component
AUDIT Alcohol Screening	2.16.840.1.113883.3.526.2.1919	Numerator
AUDIT-C Alcohol Screening	2.16.840.1.113883.3.526.2.1929	Numerator
Single Question Alcohol Screening	2.16.840.1.113883.3.526.2.1930	Numerator
Alcohol and/or drug screening (Other)	N/A	Numerator
DAST Prescription and Illicit Drug Use Screening	2.16.840.1.113883.3.526.2.1932	Numerator
DAST-10 Prescription and Illicit Drug Use Screening	2.16.840.1.113883.3.526.2.1933	Numerator
Single Question Prescription and Illicit Drug Use Screening	2.16.840.1.113883.3.526.2.1934	Numerator
Tobacco Use Cessation Counseling	2.16.840.1.113883.3.526.2.424	Numerator
Tobacco Use Screening	2.16.840.1.113883.3.526.2.1372	Numerator

BH08_01 Value Set: Exclusions

Value Set	Value Set Description	Measure Component
BH08_01: Codes for Hospice	Codes to identify hospice	Denominator Exclusion
BH08_01: Documentation of chronic pain management	Documentation that a pain contract agreement exists	Denominator Exclusion
BH08_01: Medical Reasons for Not Screening	Documentation of medical reason(s) for not screening	Denominator Exclusion

Code sets for non-claims-based measures are provided as guidance for participating hospitals, but may not encompass all codes used by participating hosspitals and/or fully align with hospital- or system-specific chart/EHR documentation practices. The State is committed to working in close partnership with

participating hospitals and providing technical assistance. Please submit any hospital- or system-specific questions via email to QIP-NJ@pcgus.com.

Measure BH09: Timely Transmission of Transition Record (Behavioral Health)

Table Name	Table Description	Measure Component
Table BH09_00	Codes to Identify a Behavioral Health Diagnosis	Denominator
Table BH09M06_01a	Codes to Identify Patients Discharged from Inpatient Facility (Type of Bill)	Denominator
Table BH09M06_01b	Codes to Identify Patients Discharged from Inpatient Facility (Discharge Status)	Denominator
Table BH09M06_02	Codes to Identify Discharge Exclusions	Denominator Exclusion

Code sets for non-claims-based measures are provided as guidance for participating hospitals, but may not encompass all codes used by participating hosspitals and/or fully align with hospital- or system-specific chart/EHR documentation practices. The State is committed to working in close partnership with participating hospitals and providing technical assistance. Please submit any hospital- or system-specific questions via email to QIP-NJ@pcgus.com.

Measure BH10: 3-Item Care Transitions Measure (CTM-3)

Please refer to the measure specifications for Measure BH10 for the list of tools acceptable for this measure.

Measure BH11: Use of a Standardized Screening Tool for Social Determinants of Health

Please refer to the measure specifications for Measure BH11 for the list of tools acceptable for this measure.

Measure M001: Severe Maternal Morbidity (SMM)

Table Name	Table Description	Measure Component
Table M01_00	Severe Maternal Morbidity Indicators and Corresponding ICD Codes	Numerator
M1M4M5Denom_APR_DRG_Detail	M1M2M5Denom_APR_DRG_Detail	Denominator
Table M01_02	Diagnoses and Procedures for Exclusion	Denominator Exclusions

Measure M002: PC-02 Cesarean Birth

Table Name	Table Description	Measure Components
Table M02_00	Diagnosis and Procedure Codes to Identify Outcome of Delivery	Denominator
Table M02_01	Diagnosis Codes for Vertex Presentation	Denominator
Table M02_02	Diagnosis Codes to Identify Gestational Weeks Completed	Denominator
Table M02_03	Diagnosis and Procedure Codes to Identify Cesarean births	Numerator
Table M02_04	Diagnosis Codes to Identify Multiple Gestations and Other Presentations	Denominator Exclusions

Code sets for non-claims-based measures are provided as guidance for participating hospitals, but may not encompass all codes used by participating hosspitals and/or fully align with hospital- or system-specific chart/EHR documentation practices. The State is committed to working in close partnership with participating hospitals and providing technical assistance. Please submit any hospital- or system-specific questions via email to QIP-NJ@pcgus.com.

Measure M003: Postpartum Depression Screening (PDS-E)

Value Set Name / Table Name	Value Set OID / Table Description	Measure Component
M03_Deliveries	2.16.840.1.113883.3.464.1004.1072	Denominator
Table M03_01	Codes to Document Depression Screen	Numerator
M03_Hospice > Hospice Encounter	2.16.840.1.113883.3.464.1004.1761	Denominator Exclusion
M03_Hospice > Hospice Intervention	2.16.840.1.113883.3.464.1004.1762	Denominator Exclusion
Table M03_02	Codes to Identify Discharge Exclusions	Denominator Exclusion
Table M03_03	LOINC Codes for Validated Screen Tools	Numerator

Code sets for non-claims-based measures are provided as guidance for participating hospitals, but may not encompass all codes used by participating hosspitals and/or fully align with hospital- or system-specific chart/EHR documentation practices. The State is committed to working in close partnership with participating hospitals and providing technical assistance. Please submit any hospital- or system-specific questions via email to QIP-NJ@pcgus.com.

Measure M004: Postpartum Care (PPC)

Value Set Name	Value Set OID	Measure Component
M04_DetailOID > Acute Inpatient	2.16.840.1.113883.3.464.1004.1810	Denominator Exclusion
Acute Inpatient POS	2.16.840.1.113883.3.464.1004.1027	Denominator Exclusion
Cervical Cytology Lab Test	2.16.840.1.113883.3.464.1004.1525	Numerator
Cervical Cytology Result or Finding	2.16.840.1.113883.3.464.1004.1524	Numerator
M1M4M5Denom_APR_DRG_Detail	N/A	Denominator
Hospice Encounter	2.16.840.1.113883.3.464.1004.1761	Denominator Exclusion
Hospice Intervention	2.16.840.1.113883.3.464.1004.1762	Denominator Exclusion
Non-live Births	2.16.840.1.113883.3.464.1004.1187	Denominator Exclusion
Online Assessments	2.16.840.1.113883.3.464.1004.1446	Numerator
Postpartum Bundled Services	2.16.840.1.113883.3.464.1004.1217	Numerator
Postpartum Visits	2.16.840.1.113883.3.464.1004.1218	Numerator
Pregnancy Diagnosis	2.16.840.1.113883.3.464.1004.1220	(Prenatal req.)
Prenatal Bundled Services	2.16.840.1.113883.3.464.1004.1223	(Prenatal req.)
Prenatal Visits	2.16.840.1.113883.3.464.1004.1225	(Prenatal req.)
Stand Alone Prenatal Visits	2.16.840.1.113883.3.464.1004.1240	(Prenatal req.)

Telephone Visits	2.16.840.1.113883.3.464.1004.1246	Numerator

Measure M005: Treatment of SUD in Pregnant Women (Initiation of Alcohol and Other Drug Treatment) (IET – I)

IET Master Table

Value Set Name	Value Set OID	Measure Component
M1M4M5Denom_APR_DRG_Detail	N/A	Denominator
Alcohol Abuse and Dependence	2.16.840.1.113883.3.464.1004.1424	Denominator
AOD Abuse and Dependence	2.16.840.1.113883.3.464.1004.1013	Denominator
AOD Medication Treatment	2.16.840.1.113883.3.464.1004.2017	Denominator Exclusion (if dispensing event during 60 d prior to IESD)
Detoxification	2.16.840.1.113883.3.464.1004.1076	Denominator (combined with Dependence v.s.)
ED	2.16.840.1.113883.3.464.1004.1086	Denominator (combined with Dependence v.s.)
Hospice Encounter	2.16.840.1.113883.3.464.1004.1761	Denominator Exclusion
Hospice Intervention	2.16.840.1.113883.3.464.1004.1762	Denominator Exclusion
IET POS Group 1	2.16.840.1.113883.3.464.1004.1129	Denominator (combined with Dependence v.s.)
IET POS Group 2	2.16.840.1.113883.3.464.1004.1130	Denominator (combined with Dependence v.s.)
IET Stand Alone Visits	2.16.840.1.113883.3.464.1004.1131	Numerator (combined with Dependence v.s.)
IET Visits Group 1	2.16.840.1.113883.3.464.1004.1132	Numerator (combined with Dependence v.s.)
IET Visits Group 2	2.16.840.1.113883.3.464.1004.1133	Numerator (combined with Dependence v.s.)
Inpatient Stay	2.16.840.1.113883.3.464.1004.1395	Numerator and Denominator

Observation	2.16.840.1.113883.3.464.1004.1191	Numerator (combined with Dependence v.s.)
Online Assessments	2.16.840.1.113883.3.464.1004.1446	Denominator (combined with Dependence v.s.)
Opioid Abuse and Dependence	2.16.840.1.113883.3.464.1004.1425	Denominator
Other Drug Abuse and Dependence	2.16.840.1.113883.3.464.1004.1426	Denominator
OUD Monthly Office Based Treatment	2.16.840.1.113883.3.464.1004.2220	Denominator (combined with Dependence v.s.)
OUD Weekly Drug Treatment Service	2.16.840.1.113883.3.464.1004.2221	Denominator (combined with Dependence v.s.)
OUD Weekly Non-Drug Service	2.16.840.1.113883.3.464.1004.2222	Denominator (combined with Dependence v.s.)
Telephone Visits	2.16.840.1.113883.3.464.1004.1246	Denominator (combined with Dependence v.s.)

Opioid Use Disorder Treatment Medications List

Value Set Name	Value Set OID	Measure Component
Buprenorphine Implant	2.16.840.1.113883.3.464.1004.1970	Denominator Exclusion (if dispensing event during 60 d prior to IESD)
Buprenorphine Injection	2.16.840.1.113883.3.464.1004.1969	Denominator Exclusion (if dispensing event during 60 d prior to IESD)
Buprenorphine Naloxone	2.16.840.1.113883.3.464.1004.1971	Denominator Exclusion (if dispensing event during 60 d prior to IESD)
Buprenorphine Oral	2.16.840.1.113883.3.464.1004.1968	Denominator Exclusion (if dispensing event during 60 d prior to IESD)

Buprenorphine Oral Weekly	2.16.840.1.113883.3.464.1004.2219	Denominator Exclusion (if dispensing event during 60 d prior to IESD)
Methadone Oral	2.16.840.1.113883.3.464.1004.1972	Denominator Exclusion (if dispensing event during 60 d prior to IESD)
Methadone Oral Weekly	2.16.840.1.113883.3.464.1004.2218	Denominator Exclusion (if dispensing event during 60 d prior to IESD)
Naltrexone Injection	2.16.840.1.113883.3.464.1004.1967	Denominator Exclusion (if dispensing event during 60 d prior to IESD)

Alcohol Use Disorder Treatment Medications List

Value Set Name	Value Set OID	Measure Component
Aldehyde dehydrogenase inhibitors	N/A	Denominator Exclusion (if dispensing event during 60 d prior to IESD)
Antagonist	N/A, 2.16.840.1.113883.3.464.1004.1967	Denominator Exclusion (if dispensing event during 60 d prior to IESD)
Other	N/A	Denominator Exclusion (if dispensing event during 60 d prior to IESD)

Measure M006: Timely Transmission of Transition Record (Maternal Health)

Table Name	Table Description	Measure Component
Table M03_Deliveries	Codes to Identify a Maternal Health Procedure	Denominator
Table M06_00	Codes to Identify a Maternal Health Diagnosis	Denominator
Table BH09M06_01a	Codes to Identify Patients Discharged from Inpatient Facility (Type of Bill)	Denominator
Table BH09M06_01b	Codes to Identify Patients Discharged from Inpatient Facility (Discharge Status)	Denominator
Table BH09M06_02	Codes to Identify Discharge Exclusions	Denominator Exclusion

Code sets for non-claims-based measures are provided as guidance for participating hospitals, but may not encompass all codes used by participating hosspitals and/or fully align with hospital- or system-specific chart/EHR documentation practices. The State is committed to working in close partnership with participating hospitals and providing technical assistance. Please submit any hospital- or system-specific questions via email to QIP-NJ@pcgus.com.

Measure M007: Treatment of Severe Hypertension

Table Name	Table Description	Measure Component
Table M07_00	Recommended First-line Drug Therapies	Numerator
Table M07_01	Pre-existing or Gestational Hypertension, Eclampsia/Pre-eclampsia Codes	Denominator
Table M07_02	Gestational Edema and Unspecified Hypertension Codes	Denominator Exclusion

Code sets for non-claims-based measures are provided as guidance for participating hospitals, but may not encompass all codes used by participating hosspitals and/or fully align with hospital- or system-specific chart/EHR documentation practices. The State is committed to working in close partnership with participating hospitals and providing technical assistance. Please submit any hospital- or system-specific questions via email to QIP-NJ@pcgus.com.

Measure M008: 3-Item Care Transitions Measure (CTM-3)

Please refer to the measure specifications for Measure M008 for the list of tools acceptable for this measure.

Measure M009: Use of a Standardized Screening Tool for Social Determinants of Health

Please refer to the measure specifications for Measure M009 for the list of tools acceptable for this measure.

Appendix B: Glossary of Terms

Term	Definition
AAFP	American Academy of Family Physicians
ACH	Acute Care Hospital
AHRQ	Agency for Healthcare Research and Quality
AIM	Alliance for Innovation on Maternal Health
AMA	American Medical Association
AMA-PCPI	American Medical Association – Physician Consortium for Performance Improvement
AMHR	Adult Mental Health Rehabilitation
AOD	Alcohol or other drug
ASAM	American Society of Addiction Medicine
AUDIT	The Alcohol Use Disorders Identification Test
AUDIT-C	The Alcohol Use Disorders Identification Test-Concise
Baseline Period	This is the time period for which the first measurement will be reported and subsequent performance measured against. Each measure's data source and experience period will impact the baseline period. The MMIS baseline period will initially be 2020 to set the overall measure improvement target goal (ITG).
BDI	Beck Depression Inventory
BH	Behavioral Health
BP	Blood Pressure
CAGE Questionnaire for Detecting Alcoholism	Cut-Annoyed-Guilty-Eye Questionnaire for Detecting Alcoholism
CAGE-AID	CAGE Adapted to Include Drug Use
CAHPS	Consumer Assessment of Healthcare Providers and Systems
Calendar year	Annual QIP-NJ measurement will be based on the calendar year as compared to the federal fiscal year or state fiscal year as some measure sets allow.
CCS	Clinical Classifications Software
Claim Type(s)	The claim type represents required data components utilized for the adjudication of a claim for payment. The New Jersey claim type values that were used for programming the MMIS measures are identified for each MMIS measure.
CMS	Centers for Medicare and Medicaid Services
Continuous Eligibility	This field indicates whether continuous eligibility applies to the measure. If it does not, N/A will be marked.
Continuous Eligibility/ Risk Adjustment/ Sampling Methodology	This field provides instructions if any of these elements apply to the measure.

CPT	Current Procedural Terminology
CTM-3	3-Item Care Transitions Measure
CUDOS	Clinically Useful Depression Outcome Scale
DAST	Drug Abuse Screening Test
Data Elements	The Data Elements section of some of the chart-based measures is designed to be a starting point for data collection from the medical chart and/or EHR. As it may not be inclusive of every item needed to report the measure accurately and completely, a thorough study of the measure's numerator and denominator, inclusion and exclusion criteria and collection procedures will be required to determine all of the data elements needed from the medical chart or the EHR.
Data Source	Indicates the method of the data collection (MMIS, Chart/EHR, Instrument-based)
Databook	Term used to refer to the Measurement Specifications and Submission Guidelines
Denominator	Defines the general criteria which identifies the patient population eligible for measurement.
DEPS	Depression Scale
DHS	Department of Human Services
DMAHS	Department of Medical Assistance and Human Services
DME	Durable Medical Equipment
DO	Doctor of Osteopathy
DOB	Date of Birth
DOH	Department of Health
DSRIP	Delivery System Reform Incentive Payment
ECDS	Electronic Clinical Data System
ECHO	Experience of Care & Health Outcomes
ED	Emergency Department
EHR	Electronic Health Record
EPDS	Edinburgh Postnatal Depression Scale
EPDST	Early and Periodic Screening, Diagnostic and Treatment
Exceptions	Criteria used to remove a patient from the denominator when the patient does not receive a therapy or service and that therapy or service would not be appropriate due to patient-specific conditions. These are not absolute and are generally based on clinical judgment, individual patient characteristics, or patient preferences (may be medical or non-medical).
Exclusions	Criteria used to remove a patient from the denominator. These are absolute; therefore, clinical judgment does not enter into the decision-making process.
FFS	Fee-for-service
FKA	Formerly Known As
FND	Fagerstrom Test for Nicotine Dependence
FQHC	Federally Qualified Health Center
FUA-AD	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence

FUH	Follow-Up After Hospitalization for Mental Illness
FUM	Follow0Up After Emergency Department Visit for Mental Illness
HAM-D	Hamilton Rating Scale for Depression
HCPCS	Healthcare Common Procedure Coding System
HEDIS	Healthcare Effectiveness Data and Information Set
HTN	Hypertension
ICD	International Classification of Disease
IESD	Index Episode Start Date
IET – E	Engagement in Alcohol and Other Drug Abuse or Dependence Treatment
IET - I	Initiation of Alcohol and Other Drug Abuse or Dependence Treatment
Inpatient or Emergency Department Setting	This refers to any measure that only considers care that was provided within the inpatient or emergency department setting and is information available to the hospital.
IPF	Inpatient Facility
ITG	Improvement Target Goal
LOINC	Logical Observation Identifiers Names and Codes
MAT	Medication Assisted Treatment
MCO	Managed Care Organization
MD	Doctor of Medicine
MDI	Major Depression Inventory
Measure and designated domain / number	Provides the name of the measure, the domain, and the respective measure number.
Measure Description	Provides a short explanation of the purpose of the measure.
Measure Qualifications	This field allows for additional information to be included in the measure specification. This may include such information as links to the measure steward, references to usage of the measure in other data sets, or it may indicate where the original specification was adjusted to more accurately follow the objectives of the QIP-NJ program (e.g., changes to measure stratifications).
Measure Steward	The measure steward is the entity that developed and maintains the original measure specifications. This information is provided to assist the hospital in determining whether the hospital currently collects and reports the measure for other programs. The measure steward provides the detailed specification information regarding the measure that should be reviewed to support the hospital's measurement processes.
Measure Steward Version	Through the measure maintenance process, measure specifications are adjusted and refined based on the most currently available clinical and technical information. This results in different specification versions in use for the same measure. To ensure that hospitals can compare the QIP-NJ measure specification to the measure steward's version, the version number is provided. When codes were referenced from multiple versions of the measure, the source for each code type is noted.

MMC	Medicaid Managed Care
MMCO	Medicaid Managed Care Organization
MMIS	Medicaid Management Information System
MSIS	Medicaid Statistical Information System
Multi-Setting	This refers to any MMIS or EHR measure that considers care that was received across multiple cares settings.
MY	Measurement Year
NCQA	National Committee for Quality Assurance
NDC	National Drug Code
NIDA	National Institute on Drug Abuse
NIMH	National Institute of Mental Health
NJ	New Jersey
NMASSIST	NIDA-Modified Alcohol, Smoking and Substance. Involvement Screening Test
NQF#	The National Quality Forum (NQF) is a non-profit organization that endorses and publicly reports health care quality measure specifications. If the NQF has endorsed a measure, the NQF is provided to assist the hospital in determining whether the hospital currently collects and reports the measure for other programs.
NUBC	National Uniform Billing Committee
Numerator	Defines the specific criteria that identifies the portion of the patient population that meet the specific performance measurement.
OID	Object Identifier
OUD	Opioid Use Disorder
Outpatient Setting	This refers to any measure that only considers care that was provided in an outpatient setting. This information may be available at the hospital-based clinic if the service is offered.
P4P	Pay for Performance
PCG	Public Consulting Group
PCP	Primary care physician
PDS	Preventative Care and Screening: Screening for Depression and Follow-Up
PDS-E	Postpartum Depression Screening
Percentage	An indicator of healthcare to monitor measure compliance. A percentage measures the number of a certain set of events that are proportional to one another. The numerator and denominator are the same unit of measurement and the numerator is a subset of the denominator.
PHQ	Patient Health Questionnaire
POS	Place of Service
PPC	Postpartum Care
PRA	Perinatal Risk Assessment
PRAPARE	Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences
PROMIS	Patient-Reported Outcomes Measurement Information System
QIP-NJ	Quality Improvement Program - New Jersey
QMC	Quality Measures Committee

Rate	This is a specific kind of ratio, in which two measurements are related to each other but do not utilize the same unit of measurement. The numerator is not a subset of the denominator when a rate is calculated. A rate measures the number of events compared to another unit of measurement, for example the utilization per member months.
Result	The calculated performance. This can be expressed as either a rate or percentage
Risk Adjustment	This field indicates whether risk adjustment applies to the measure. If it does not, NA will be marked.
RN	Registered Nurse
Sampling	This field indicates whether sampling applies to the measure. If it does not, NA will be marked.
SBIRT	Screening, brief intervention, and referral to treatment
SDOH	Social Determinants of Health
Setting of Care	This field lists where the service(s) was rendered and helps identify which provider type has the information available.
SFTP	Secure Files Transfer Portal
SHTN	Severe hypertension
SMM	Severe Maternal Morbidity
SUD	Substance use disorder
TAPS-1	Tobacco, Alcohol, Prescription Medication and other Substance Use
TICS	Two-Item Conjoint Screen
VBP	Value-Based Purchasing
VSC	Value Set Compendium